UNITED STATES OF AMERICA DEPARTMENT OF DEFENSE

TASK FORCE ON MENTAL HEALTH

OPEN SESSION

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P R O C E E D I N G S

(1:16 p.m.)

LTG KILEY: I'm Dr. Kevin Kiley. I'm one of the co-chairs for Mental Health Task Force. We just got back from a great

visit in San Francisco, which is why we're a little bit late in getting here. Thank you for waiting.

I'd like to welcome all to this meeting of the congressionally-directed Task Force on Mental Health. We have much to accomplish today as we endeavor to gather the information needed to deliver the Task Force's report to the Secretary of Defense containing an assessment and recommendations for improving the facilitation of mental health services provided to the men and women of the armed forces and their families.

Ms. Ellen Embrey, who's the designated federal official of the Task Force's Parent Federal Advisory Committee, the Defense Health Board, had an unavoidable

conflict and will not be able to attend the meeting. In her absence she has appointed Colonel Jeffrey Davies as the Army Surgeon General Executive Officer to serve as the alternate designated federal official.

Colonel Davies, would you please call the meeting to order?

COL DAVIES: Thank you, Lt. General Kiley. As the acting designated federal

official for the Defense Health Board, the Federal Advisory Committee to the Secretary of Defense, which serves as a continuing scientific advisory body to the Assistant Secretary of Defense for Health Affairs, and the surgeons generals of the military departments, I hereby call this meeting of the congressionally-directed Task Force on Mental Health, a Defense Board Health subcommittee, to order.

LTG KILEY: Thank you, Colonel Davies. Good afternoon. We're the Department of Defense Task Force on Mental

Health, and we thank you for taking time out of your busy schedules to be here.

I'd like to take a moment and introduce ourselves. I'm first, as I said, Dr. Kevin Kiley of the Army Surgeon General.

DR. ZEISS: I'm Dr. Antonette Zeiss. I'm the Deputy Chief Consultant for the Office of Mental Health Services in VA Central office, and I am the VA representative to the Task Force.

COL CAMPISE: Good afternoon. I'm Rick Campise. I'm a pediatric psychologist. I work for the Air Force Surgeon General as

the Chief of Deployment and Behavioral Health.

CAPT McKEATHERN: Good afternoon. I'm Margaret McKeathern. I'm a child mental health psychiatrist and the naval representative to the Task Force.

COL ORMAN: I'm Dr. Dave Orman. I'm an adult psychiatrist. I work full time in support of the Task Force for General

Kiley.

LCDR WERBEL: Good afternoon. Aaron Werbel. I'm a Navy clinical psychiatrist. I'm the Behavioral Health Affairs Officer at Headquarters, Marine Corps.

LT COL DOUGLAS: Lt. Colonel Jon Douglas, Headquarters Marine Corps Manpower and Reserve Affairs.

DR. McCURDY: I'm Dr. Layton McCurdy. I'm an adult psychiatrist and work at the Medical University of South Carolina in Charleston.

CAPT KLAM: I'm Dr. Warren Klam. I'm a psychiatrist, and I am the Psychiatry Specialty Leader for Navy Medicine.

DR. McCORMICK: And I'm Dr. Dick

McCormick. I'm a clinical psychiatrist.

LTG KILEY: Okay, the congressionally- mandated Task Force asked to look into the current military health care system. The overall intent of our visit here

today is to gain insight into that system and ultimately provide Congress with recommendations for areas of improvement, but also to acknowledge areas that are flourishing. We asked you to be here today because we are particularly interested in your perspective and experiences. We'd also like to ask you to be mindful of your fellow persons here and allow those who are speaking courtesy and respect.

Colonel Dr. Tom Burke has some administrative remarks to make before our first speaker and, after a few briefings, we'll have an open session, open for the public. Dr. Burke?

DR. BURKE: Thank you, Dr. Kiley. Good afternoon, welcome. I'm Dr. Tom Burke. I'm the executive secretary of the DoD Task Force. I would like to thank the Task Force support staff for helping with the arrangements for this meeting and for all of

22 the speakers who have worked hard to prepare

1 briefings for the Task Force.
2 I just have a couple of
3 administrative announcements for all
4 attendees. Would you please be sure that you
5 sign in at the table outside the door. This
6 session is open and is being transcribed.
7 Please be sure to state your name before
8 speaking and use the microphone so that our
9 transcriber can accurately report your
10 questions. Please bear in mind that the
11 session is being transcribed and will be made
12 available to the public via a public website.
13 Bear this in mind when speaking to the Task
14 Force.
15 The next full Task Force meeting
16 will be Monday through Wednesday, 18 through
17 20 December in Washington, D.C. The
18 tentative agenda includes informational
19 presentations from representatives from
20 TRICARE Health Affairs on Suicide Prevention,
21 OSD Reserve Affairs for Self Protection on
22 the PDHA, the postdeployment health

9

assessment, and the postdeployment health reassessment, as well as hearing from veteran service organizations, military service organizations, the Nation Guard and Reserve.

Thank you, General Kiley.

LTG KILEY: Thank you, Dr. Burke. I would like to introduce now our first speaker for the afternoon, Ms. Kerry Childress. Ms. Childress currently serves as a communications officer and congressional liaison for the VA Palo Alto Health Care System. Prior to this assignment, Ms. Childress worked at the VA Headquarters in Washington, D.C., as the Director of Communications for all of the Veterans Health Administration. As such, she developed communications policy and strategy, including guidance to the Office of the Undersecretary of Health, Central Office -- (off mike)-- and Network and Field Facilities; Vietnam Air/Navy veteran over 22 years of public affairs; experience includes working at the

10

U.S. Soldiers and Airmen's Home, Arlington

National Cemetery, Military District of Washington, and as the associate editor of Navy Times. She graduated summa cum laude from the University of Maryland and holds a master's degree from American University, Public Relations.

Ms. Childress, thank you very much for joining us today. We look forward to your comments.

MS. CHILDRESS: Thank you. There's probably no better or no more credible source to speak about traumatic brain injury than the men and women who've suffered it. Consequently, I want to start my presentation today with a news clip from The Jim Lehrer Newshour.

(VIDEO PRESENTATION)

MS. CHILDRESS: When Marine Corps Jason Poole was on his third tour of duty in Iraq, 10 days short of coming home when an IED exploded and sent shrapnel all over his

body, including through the back of one ear and out the front of his face, virtually shattering every bone in his head, miraculously, he survived. And when he arrived at the VA in Palo Alto, he couldn't

walk, he couldn't talk. He is breathing through a tracheotomy and being fed through a tube in his stomach. I am here to tell you two years later that Jason Poole is living on his own and is in community college.

I see almost daily miracles happen with these men and women. It is truly, truly an honor and an inspiration to work at the VA and see them and see their remarkable attitudes. And the VA developed a program called the Polytrauma Rehabilitation Centers, and there are four centers, one at Palo Alto, one at Tampa, one in Minneapolis, and one in Richmond, Virginia. These four centers were selected because all four of these hospitals had a traumatic brain injury unit.

The term, of course, "polytrauma"

comes from the fact that rarely -- rarely do they return from combat with a brain injury and that's the only thing they have wrong with them. Oftentimes there are loss of limbs, loss of eyesight, and PTSD to accompany it. So, consequently, the polytrauma centers, rehabilitation centers, were developed in order to provide a coordinated kind of care for these men and

women.

And by "coordinated" I mean we have a national center for blind rehabilitation, spinal injury units, national center for PTSD, and numerous other type -- any type of prosthetics, any type of injury that they had incurred is taken care of either at the same time or after the traumatic brain injury rehabilitation takes place.

We're talking sometimes months and months. We have now seen just over 1,000 men and women coming back from Iraq and Afghanistan. Of those, about half of them

were actually injured in combat. We anticipate that anywhere from maybe 50 to 60 percent of the men and women that we're treating for traumatic brain injury today would not have survived Gulf War One, which is a pretty astounding figure when you think about it, and there's three principal reasons for that: 1) body armor; 2) the Kevlar helmet; and 3) and perhaps most importantly, the extraordinary battlefield medicine that's provided to these men and women, and the ability to evacuate them to a major hospital oftentimes within 12 hours.

So the fact that Jason Poole survived came as somewhat of a surprise to everyone. Another one of our patients on the unit that General Kiley had an opportunity to meet yesterday is Marine Corporal Tim Jeffers. Tim Jeffers not only withstood a very serious brain injury, the loss of an eye and an ear, but he is also a double amputee, lost both his legs. And I bring this up to

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you because of all people, he would know.

I remember one day talking to Tim and him saying to me, "You know, I'm not at all worried about walking again. I know I'm going to walk again. I just want to get my brain fixed." You know, I would never, ever trivialize the loss of a limb ever, but these men and women coming back today are young and so fed, and prosthetics are so good today that pretty much all of them will be able to do anything they could do before after time and a lot of rehabilitation and practice.

But, folks, that is not true of the brain-injured. There is no prosthetic for the brain. It doesn't heal itself, and the only thing that we can do through long, long months and tedious hours of rehabilitation to

try and teach other portions of the brain to pick up where the part of the brain was that was damaged.

In the piece earlier you saw Sergeant Frank Sandabaugh. Well, Frank not

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only has difficulty talking but Frank can't even swallow automatically. Our speech therapist had to spend weeks teaching Frank how to swallow, and for the rest of his life Frank will have to consciously swallow because the automatic swallowing reflex in the brain was too damaged.

He's going to have difficulty speaking although, believe me, he's come a long way. Whether he'll ever be able to speak fully and accurately again is yet to be seen because he's still going through the rehab.

He does have paralysis on the right side of his body, but I will tell you, he's walking, and he's walking clear up and down hallways. He's doing very, very well.

And he's had his cranioplasty, so that big dent in his head, he looks very normal now. But I tell you this because Frank still has a long way to go, and his wife has been by his side since the day he

22 arrived at Palo Alto, and that's an area

where the VA has kind of had to learn how to cope with family members when the war began.

Keep in mind the VA's dealt with family members all along, but we were kind of used to dealing with children and sometimes even grandchildren, sometimes even great grandchildren of our patients. Now we were dealing with mothers and fathers, and we were dealing with young wives that were in their early 20s with young children.

There's another area that we had to learn about, and that is a lot of these men and women who are in the military join the military to get a step up in life. They came from low income families. Now they're injured, very severely injured, and the families want to be with them. So oftentimes -- and I say oftentimes, more often than not these families spend all the money they have to get to Palo Alto to be with their loved one, and then they're looking at the hotel costs in Palo Alto. Astronomical. I mean by

for all accounts many of these families simply didn't know what to do, and, quite frankly, neither did we 'cause guess what. The VA, by law, cannot use appropriated funds to take care of family members.

And so we had to go to the community. And I will tell you, say what you like about the media, the media served the VA well. We had great newscasts that went out to the community and let them know that we had this need. Within a year and a half we raised $1.5 million, half the money -- all the money we needed and half the money for a Fisher House, which we opened, by the way, in April of this year. It's a 21-suite Fisher House, and it's one of the largest they've ever built to house the families of these service members.

But guess what. That still wasn't enough. We've had a waiting list on our Fisher House since it opened, and we still have families that need transportation, that

needed food. One of the families that

General Kiley met the patient yesterday was Corporal Angel Gomez. Angel arrived like Jason, unable to walk or talk, very severely injured and still has paralysis on one side. Angel was the second oldest of eight children, which meant there were still six at home. His father was an immigrant Mexican farmer that lived outside of Fresno. When Angel showed up at our doors, so did the entire family. Fortunately, because of the generosity and the wonderful caring, outpouring that we saw from the Bay Area community, we had money to put the Gomez family up in an apartment in Mountain View in a Hispanic community, as neither of his parents spoke any English.

So I thank -- I thank the Bay Area very, very much. I cannot tell you how much they have helped us help the families, because it's very, very difficult for our nurses, and our social workers, and our

therapists whose primary focus is on the patients themselves to suddenly have families and not know how to take care of them. So I'm very, very, indebted to the community for that.

We do still have money coming in that helps us with the families and helps them take care of it. You know, we too often, we focus on the men and women who are injured, justifiably, but we often forget how devastating these injuries are to the family unit. And so that has been a real learning experience for us, and I'm happy to say that we have also learned how to incorporate many of these families into our actual rehabilitation.

And it's a critical part of the rehabilitation, not just for the patient but also for the family, 'cause guess who's taking care of these patients when they leave the VA? It's the family members, and when they've been with the patient all through the

rehabilitation, it makes a huge difference. A huge difference. So I thank the community for that.

The other thing, quite frankly -- and we're all still learning it, certainly DoD and VA together -- and that's just exactly what the brain is capable of doing even when severely injured. There is an organization called the Defense and Veterans

Brain Injury Centers. There's one at all four of our polytrauma centers. There's one at Walter Reed, one at Bethesda, and one in Charlottesville. And it's a very, very close collaboration that DoD and VA have in researching the brain and researching these injuries.

I think we will see the Defense and Veterans Brain Injury Centers start taking a much bigger role in a lot of the research coming down the pike because, as they said in the very first -- in the news clip that you saw -- this will be one of the signature

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injuries coming out of the war. I really believe we're going to be seeing much more of this, and not unlike PTSD, we're going to see brain injury and people with brain injuries surfacing five, ten years down the road after they have returned.

We've already seen it. You saw where Claudia Carrion (?) was sent home. Another example of that is the National Guardsman Sergeant Alec Geise (?), who was -- an IED caused a truck to literally fall on top of him. The Army got him to a hospital, saved his life, took care of all of the body

injuries -- and there were a lot -- and sent him home.

He hadn't been home more than about a month and his wife said, "You are not normal. There's just none of you here that was here before you went to combat. What is wrong with you?"

And at first they thought it was PTSD. There are some very similar symptoms

between PTSD and traumatic brain injury. But they finally got Alec to a VA and they tested him for brain injury.

And he ended up at Palo Alto for over a year and a half, rehabing with a major brain injury. I will also tell you that Alec had PTSD as well, and that's not uncommon either. But you combine the two, and you're talking about somebody who needs lots and lots of rehab and counseling.

And I would love to tell you that Alec spent that year and a half with us, went through our PTSD program and is just doing great now. I would love to be able to tell you that. He is doing much, much better. He is very much still married and still very involved in his children's lives, but he ran

a construction company before he went to war, and he will never be able to do that again. He simply cannot multitask and do the math and do the things that are necessary to run a big business. So Alec will never be normal,

but he is doing much, much better.

And I just bring that up to you because Alec and Claudia also bring up a really important point which the clip brought up as well, and that is we're going to see guys coming, men and women, coming back from the war who don't look injured. It's called the silent injury, again not unlike PTSD, and these people perhaps have even a tougher time than people who come back with amputations. It's very obvious when you see somebody without a limb that they've suffered during a war, and there's a lot of outpouring and sympathy that goes to them.

It's a lot harder for people to have sympathy for Claudia when they go up and talk to her and have just met her the day before, and she looks at them like she had no idea who they are. It's very, very difficult.

So I'm hoping -- I know that DoD

has begun doing a lot more screening for

traumatic brain injury, particularly with troops that have been through one or two blasts, and I think that's where we've got to get to first, again not unlike PTSD. And that is catch them early when they begin to have some of these symptoms before they move into actually the same kinds of things happen: Divorce, alcoholism, isolationism because people don't understand what they're dealing with. When they get help, it makes all the difference in the world.

And we're able to show them how to compensate. We can't rebuild the brain. That doesn't happen, but we teach them, one, how to compensate, like we did with Claudia and the iPod.

When you see Claudia she will have that in her hands all the time. She lives with that iPod 'cause that is her memory. I think it was one of the most beautiful statements that she made in her interview when she said, "I don't have my memory and my

brain anymore. I carry it in my hand."

And so I think that was very, very telling, and I'm hoping that when these folks come back with these silent injuries, with the PTSD, with traumatic brain injury, that we're all sympathetic and understanding. I ask everyone, in an effort to outreach to the community, if you know somebody who's struggling, if you know somebody who's not what they used to be, encourage them. Encourage them as much as you possibly can to come in and be tested.

If it's PTSD, there's treatments for that. We can help them. If it's traumatic brain injury, we can help with that, too. And it's not just the VA but DoD, too. There are solutions out there, but I will tell you, it's difficult getting people to come in for treatment. So I ask you if you can do that, that's the one thing I hope our audience here takes away from us today, is to help us do the outreach, to let folks

know that there is help for them.

And at that, I'd like to finish with one other news clip. This actually just ran last Monday on Anderson Cooper 360. General Kiley was kind enough to come out to the polytrauma center yesterday, met both of the young men that you'll see in this news clip, and I will let you know I was over there this morning, and thank you very, very much for coming because they were all thrilled that you were there. Thank you so much.

(VIDEO PRESENTATION)

MS. CHILDRESS: One of the things -- one of the times that I think that I will always, always remember is when Sergeant Alec Geise was doing an interview with the San Francisco Chronicle, and he said to the reporter, he said, "The Kevlar helmet, the body armor, and the Army saved my life, and VA is making me well." I was never so proud to work for an organization in my life.

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Thank you very much.

(Applause)

LTG KILEY: Thank you, Ms. Childress. Does anybody from the Task Force have any questions? (No response)

Okay. Thank you very much for a very moving and profound presentation.

MS. CHILDRESS: And again, thank you very much for coming yesterday. I appreciate it.

LTG KILEY: It's my honor. I think right now we're a little bit ahead. Why don't we take a 15-minute break, and we will reconvene at about 2:15 for the next two presentations, okay? Thank you.

(Recess)

LTG KILEY: I'd like Colonel Angela Pereira to introduce herself, please.

COL PEREIRA: Good afternoon. I apologize for my tardiness. I realize that I had to be checked out of the hotel, so I had to hurry up and do that.

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I'm Angela Pereira, the social work representative to the Task Force. I have a Ph.D. In social work, 23 years of active duty including two combat tours, and I'm currently at Fort Belvoir, Virginia.

LTG KILEY: Thanks, Angela. Okay, our next speaker is Major Steven Fetrow, who is from the National Guard. He's one of our great MPs. And he'll be discussing some of

the health care issues pertaining to the Guard based on his own knowledge and observation.

Major Fetrow, the floor is yours.

MAJ FETROW: Thank you. Good afternoon. On 24 September 2006, a Sacramento Bee Article makes the following statement: They claim that more than one-third of Iraq and Afghanistan veterans are currently seeking medical treatment from Veterans Health Administration, and they report symptoms of stress and other mental health disorders which, according to the

article was a 10-fold increase in the last 18 months.

As the Director of Mental Health Programs for the California Army National Guard, it's not my task to debate with the daughter media about the accuracy of these statistics; however, what it is my task to do is to assess the realities and to assist our soldiers. And that's really what we're all about is do what we can do to take care of soldiers.

I skipped over a couple of slides, intentionally, and I'm going to move directly

to the main bullets that -- my task is, here today, is to basically provide an overview of what we're doing in California as far as Mental Health Task Force and the mental health programs in this state.

So I'm going to skip over a couple of slides right off the bat.

But I want to start by saying that my passion for this is twofold: As the

General mentioned, I'm a military police officer by trade, and I've served 16 years in the Army. I'm a formal combatant and a combat veteran. So from the perspective of being one who's been over there and experienced the trials and tribulations of war itself, I wear that hat. And, obviously, from the mental health perspective and seeing the folks that have struggled and have dealt with numerous issues and pains and hurts and issues over their careers, and from things that have happened from a result of things that took place while they were overseas, I've a passion to see them get help, have a passion to see them get healthy, and I have a passion to see them be whole and contributing members of our society and of our military as

a whole. So that's kind of my two-fold passion.

We'll go to the next slide. What I'm going to do, I'm going to do two basic things for you here today. I'm going to

first start with basically showing you the mental health programs that the State of California National Guard does that I am basically am directly responsible for and supervise within the state, so, basically, what the mental health programs are that we do.

And then I'm going to show you a second slide that shows where our hands are in a whole bunch of other programs that we're not necessarily directly responsible for, it doesn't come to my desk for a sign-off, but we're intimately involved in as far as the state of California is concerned.

And so I'm going to highlight, basically, the six programs here in the state, and I don't want to insult anybody's intelligence but, just to make sure that I have provided an accurate overview, I'm going to basically detail how these programs all work and all function within the state.

I don't know that these are all

functioning the same way in every state. I don't know that they function the same way from the RRCs, but this is how we do it as far as in California.

And the first issue -- these are basically the six issues, the six programs that we deal with specifically. And again, one more caveat: The National Guard and the Reserves have some unique challenges and some unique issues when it comes to deployment and redeployment. First of all, when we redeploy, we're already discovering -- we're doing it right now in California, and I think this has pretty much become a national trend -- is they come back for redeployment at the redeployment station; they go through a health assessment, and then 90 days after they've returned to their home station, they go through a second assessment.

And the reason for that is because of one of the unique struggles of National Guard and Reserve soldiers who redeploy out

of Fort Lewis, Fort Hood, of Fort-Somewhere-Else in the country but live here in California. When they come home and they have a bad knee or hurt shoulder, or they've had some ringing in their ears or some issues, they don't want to tell those stories in Fort Hood and Fort Lewis, or Fort Wherever, because they want to come home. And they know that if they say that there at the home station, they're going to be held over on medical hold for who knows how long until they can resolve these issues. So, unfortunately, a lot of times they choose to not be completely forthright during those assessments, and then they wait.

And we're already discovering that there's a big difference between what's being said at the first assessment and what's said at the second assessment. And the reality of that is because they're active duty soldiers. When they come home, they come home to an active duty post. They come home to their

community, to their home, to their families,

to their resources that exist right there in their -- and there they have the ability to go make use of all those resources. It hasn't changed.

But our National Guard and Reserve soldiers come home, they don't have an active duty installation in a lot of places in the state of California, especially, to access with ease. They don't have the same resources and the same level of access that our active duty soldiers do, so they are spread out throughout the state for all kinds of areas that are not necessarily around an active duty post.

So that's some of the challenges that we have in the Guard and the Reserve as far as just the very nature itself of not having people contained in a very small area where we can monitor them, watch them, work with them, research them, help them, assist them in a setting that's prewar and postwar,

because they come from the civilian world before they get deployed, and then they go back to the civilian world after they redeploy. So there's so many challenges there.

These are the six programs that we work with specifically. The first one mostly everybody will be familiar with, and that's the concept of doing consultations and evaluations. Within the state of California, as any other state in the Reserves and the active component, there are a number of aspects of that: There's command consultations; there's fitness for duty; there's security background checks; there's a whole bunch of different ways that soldiers are required to go through a consultation or to go through an evaluation or some type of an assessment.

Through my experience -- I've been in this position just for a few months now -- I've received already about four command

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consultations in the last couple of months. But most of our consultations and our evaluations come from the assessments. Somebody comes back from a redeployment, they go through their posthealth assessment and redeployment assessment; they fill out their assessment; they are seen by treating physicians at the redeployment posts or/and how that takes place. And then somewhere in

that screening process they're screened out.

Somebody says this might be a soldier that would benefit from some additional treatment or for some additional screening, and so usually they'll have a second screen at the redeployment station, and then they'll be referred out for additional services.

I will say that in California the most recent data we have in the National Guard, and I just received an information paper on this two weeks ago, states that we have about less, actually less than two

percent of our returning redeployed soldiers that are actually referred for mental health services in this state. So when you hear these blowing numbers of 15, 30, 50 percent of soldiers that are redeploying or are having PTSD and are going back for treatment, that's not accurate statistic, at least for the state of California. Our soldiers aren't coming back with that level of a problem. So those are the different levels of consultations.

What we do in the state of California is kind of unique because, again,

we have a lot of different -- there's a lot of different resources we can use. And that's basically -- it's good that I'm a former MP because I know how to direct traffic, and that's a lot of times my biggest job is figuring out who goes where, which direction, and how. And we have a lot of resources to use in the state of California that are active duty resources. The active

duty facilities, our soldiers, when they come home from active duty redeployments overseas are covered for six months under the TRICARE window, can still make use of any of our military treatment facilities anywhere across the state. So that's one place that we're able to plug them in.

We're able to plug them into the VA and through vet centers. It's another location where we're able to take our soldiers. And for those of you that are unaware, the vet centers will not only treat the soldiers who were deployed but the vet centers will also care for and treat their family members. So there are resources that we're able to use there through the Veterans Administration, through the veterans center.

One of our most frequent-use resources in California is we have what's called a "State Military Reserve." And we have a huge group of folks that have put in a lot of time and a lot of dedication and have

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worked very hard to take care of our soldiers. We have a number of folks in what we call a "combat stress team" that are psychiatrists and psychologists, and licensed practicing physicians throughout the state, and they're a member of the State Military Reserve.

We're able to -- and just for example I can get a phone call in my office, I can have a commander in San Diego say, "We've got a soldier, we've got --," this issue, this issue, "this year we're going to put him in for a command evaluation.

We want him to have a fitness-for-duty evaluation. We're concerned about his mental health." I can make a phone call to an SMR representative in the Southern California area, and we can have that soldier set up to have an evaluation or an assessment, literally, within a week if need be. If it's an emergency assessment,

obviously we treat that differently than we

do a nonemergency assessment. But even in nonemergency assessments we can turn that around within a week or two weeks, usually, to make sure we have that soldier assessed and have an evaluation by a treating physician that will be able to provide some resources and referrals and get the soldier and his family or her family to help with the need.

So that's the first thing, the first area that we work under, is the consultations and evaluations.

One of the benefits of having this fall under the window, quote/unquote, of "a mental health agency" rather than one of the many other agencies or entities within the State National Guard is -- obviously, that's my passion and that's my direction, so it falls under my window. I'm managing that database. I'm watching that database, I'm making sure that the people are connected with the right people, I'm following up

making sure that care is taking place. I'm talking with the soldiers afterwards, with their families afterwards, or with commanders afterwards, with the treating physicians afterwards just making sure that all of those things take place.

A lot of times if you don't have kind of the place where it stops, you know, the-buck-stops- here kind of mentality, it can lost in the paperwork and in the shuffle. That's one of the real benefits of having a director of mental health in the state is that it's coming to one location for these evaluations.

The second program that we're directly responsible for is the issue of combat stress. Combat stress, primarily, takes place -- our combat stress team at SRPs -- takes place at the soldier readiness processing.

Can you all hear me? Is that working now? You can hear now, okay. Thank

you.

That primarily takes place at the soldier readiness processing, when they deploy and when they redeploy. And as I kind of explained that process before, we have not only the health assessment that the Department of Defense and the Department of Army has supplied us as we go through the screening process, we've also created a couple of other instruments that we use for stress evaluations, and we have supplied those to soldiers during their soldier readiness processing.

So they go through these screenings, our combat stress team is there the entire soldier readiness processing time frame. So, for example, we have one in January, and I think it's 11 days long. I will be there for 11 days long; our state social worker will be there for 11 days; and our entire combat stress team will be on site, on location for those 11 days. So when

they're going through their assessment, we have a physician that says, "Hey, I think this soldier might have an issue where we need to have an evaluation," we'd have some further screening, some further work done.

There can be an immediate referral to a mental health professional that's right there on site that can take that soldier off and work him or her individually, and do assessments and evaluations to kind of determine where the soldier is at.

Combat stress is especially relevant when we have the redeployments, and again I think I've already talked a little bit about the direction we go with that. The other aspect that we do for the state is we really serve as a subject matter expert for our family readiness groups and other entities within the state that have requests of dealing with issues of combat street.

This last week I spoke at a briefing for an Operation We Care, which is a

family readiness group meeting in the Sacramento area, of a number of soldiers' families that are spread throughout the state. Our state did two things this last deployment that we've done differently in the past, and that is we have family readiness groups, which is a wonderful program, and it keeps our soldiers involved, it keeps our families involved and plugged into what's

happening while their soldiers are deployed overseas. It's a great resource and a great support network.

However, sometimes what you have is you have, for example, an MP who lives in Modesto but the closest unit that's an MP unit for him is in San Francisco or in San Diego, or wherever else. So that soldier may travel, literally, two or three hours to be with his unit. So when they deploy overseas, it's not very realistic for a family member who lives in Modesto to attend family readiness group meetings in San Diego or

Sacramento. So they're kind of out of the loop.

So what the family readiness group did this time around, the Operation Ready Family, is they created regional and area family readiness groups that were in addition to the unit groups, and that's this Operation We Care. And so these meetings take place all throughout the state, and basically what they do is, they target soldiers whose unit is not in their geographical area.

So, for example, this past Sunday I met a whole bunch of families, family members

of soldiers that live in the Sacramento area but their soldiers are deployed with units that are outside of the Sacramento area. That way they're able to stay involved, they're able to keep resource, they're able to keep connected with what's going on and without having to make a two-or-a-three-hour drive to some other location. We found that really, really effective. And we've really

resourced them and worked well with them as well.

This next program is probably been our keystone program in the last couple of years, and it's our Imbedded Mental Health Programs. And if you've never heard about this, this is an absolutely wonderful program. We're doing this in conjunction with TRI-West. Basically, what we have done is right now in 37 of our armories across the state of California, we have what's called an "embedded mental health professional," a licensed professional in the state of California that volunteers, goes through a screening process with Tri-West, and then is assigned to a specific armory and a unit. That way every time a unit drills, when they

come back from redeployment or whatever else, every time the unit is at that armory drilling that mental health professional is on site at that unit and available, every single time.

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So we have a mental health professional right now imbedded in 37 of our armories across the state. And, obviously, our objective and our goal is to get them in all of them. The more available, the more accessible we have our mental health experts in, the more -- it's just like any other program in any other entity in the military -- the more that person is around, the more they're working with the soldiers, they're resourcing, they're providing briefings and updates and information, and they're working with family members, the more they become trusted. They become a part of the, quote/unquote, "family," and then the soldiers begin to rely on them, depend on them, and turn to them.

And also in addition to that, since our soldiers are aware that we now have that in those armories, we've also found that they'll get referrals, and we'll get

connections from other members of the command

regarding soldiers: "Hey, I don't know, I'm not real sure what's going on, but this guy has been having some problems, and maybe you should go say hi to him, go talk to him this week and see if you can connect with him." And we've really found that this program has been a very, very effective program.

We've already in just the last couple of months that I've been working with Tri-West and involved in this program, I've already seen two or three cases that were really significant, problematic, emergency kind of crisis care cases be handled in conjunction with our Tri-West imbedded professionals. And it's been a wonderful program.

It's made a big difference in the state, and it's really helped us with our mental health availability and resourcing with our units.

The next one, the Health and Welfare Program Initiative, is kind of a

brand new program that we're hoping to have completely cycled out within a year. And, basically, the concept of this is our soldiers -- for those of you that aren't familiar with the process, when we deploy, we go to what's called a soldier's readiness process or processing. And they go through all of the predeployment briefings; they get all kinds of screenings and evaluations, and things take place both medically, administratively, financially. They go through basically the whole deal, and then they go through a mobe station where they actually prepare for deployment.

They go overseas, they deploy for however long their deployment is. They come back to the same, usually the redeployment location, and then they return to home station. What we're initiating this year in California is going to have mental health representation at every step of that process. In other words, we're already there at the

SRP. The next step is we're going to begin

having one of our mental health
representatives go to the mobe station where
they're actually mobilized and become an
asset and a resource for a limited period of
time, just to stay connected, to stay
available, to stay involved, and to continue
assessments in support of that unit.

And then the additional plan is
when they're overseas, our intent right now
-- and we're still working out all of the
many details of this -- but our intent right
now is that we're going to try and target at
the six-month mark to send a mental health
team over for a mental health and welfare visit.
And at that point
we'll meet with command, we'll meet with
soldiers, we'll do some additional
assessments, and again just, we're here,
we're working with you, we care about you,
we're available. Here's some additional
resources that you may or may not be aware

of, get some goodies out, bring, you know,
the morale up a little bit and continue to
make relational connections so that when
soldiers redeploy, they've got names with
faces for the redeployment, because at the

redeployment station we'll do the same thing. We'll have that mental health representative will be at the redeployment station, will assist again in the reassessment of those soldiers when they come back on ground.

So our hope is that within the next year or two, complete a cycle with a couple of our units and come up with an assessment and evaluation for the legitimacy of this program. But I think there's a lot of potential, especially inherently with making connections and developing relationsbips with commands that will make a process of reaching out and taking care of the mental health needs of our soldiers to be greatly, greatly elevated. I really think there's a lot of potential with this. So we'll see where it

goes, but this is another one of our program.

And then the last bullet is the Joint Force Headquarters Counseling Program Initiative. This is basically a twofold process. One, I'm in the building, and I'm not there all the time, but everybody pretty much knows where my offices. I hear people laughing and throwing stuff at the door when they walk by, so I get harassed in my office

all the time. But I also have a lot of people because they're aware that we have a mental health director right there on site that will stop in, say, "Hey, do you have a few minutes, can we talk?" It's a very common, common thing that happens throughout the week.

And so what we've started doing through the direction of the joint chiefs is we're working now to develop a counseling initiative program actually at the headquarters itself. And I do a very small, limited amount of short-term sessions myself.

We also have a number of other licensed professionals within the building and within the command that are accessible and are willing and able to assist with some counseling needs and mental health issues right there in the state.

So we're not sure how this is going to take off, but the plan is right now we're working with a couple local universities to create some supervised experience opportunities and to enable our soldiers that are, at least in the Sacramento area for right now -- and this is kind of the first

step of the initiative -- to be able to receive, you know, limited counseling basically free of charge. And that's kind of where we're working at with that last bullet.

I want to say that it's only been a couple of months since I've been doing this job, but every single leader I've worked with and interacted with in the entire state of California, from the O-6 who brought me in

and hired me to the joint chiefs that I've talked with and worked with, I have never, not one time, sensed any negativity.

They are all incredibly supportive. They genuinely care about their soldiers, they care about their mental health, they care about their welfare, and they are very supportive of any initiative we've tried to push through to make working with and helping our soldiers and our airmen in the state of California work.

And I think they've also demonstrated that by putting their money where their mouth is by funding this position, which, for just public knowledge, it's not in every state. Every state doesn't have a director of mental health programs.

It's funded under the GWOT fund, and they are going through the budget change proposal to make this a state active-duty position which then will become a permanent position. And I think that's indicative of

the command's general concern for this issue and their commitment to make it work in the state of California. They've put their money behind their words, and I've found that to be very, very, very important.

It would be my own personal wish, I would love to see a director of mental health, mental health programs, state psychologists, whatever label we want to put on that person, I'd love to see that in every state. I think that would be a fantastic initiative and at every RRC to have some Director of Mental Health Program in our Behavior Sciences, or however that functions, that title would work. But I think that California has really been aggressive in working to make that happen.

The next bullet here deals with places where we're involved and -- the next slide, sorry -- and where we're involved as a department, but we're not -- we don't direct

these programs. But I'm going to highlight

these because there's a lot of stuff that the National Guard is doing, the Army is doing, the Department of Defense is doing that reaches out to soldiers in mental health issues that aren't under the mental health umbrella, and that's what this next slide hits. So if you pop the bullets on here, I highlighted six of these programs, and the first one is Marriage Enrichment.

And if you've never heard of the concept of marriage enrichment, it's a program that takes place throughout the entire country, and they take key leaders and people who are concerned about, basically, marital relationships of their soldiers, and they train them in what's call "TREP" (?) training. These TREP training certifications take place about every month all over the country. There was one last month in Denver. There's one next month in Oklahoma City. We send key leaders to get trained to basically run a marriage enrichment program. And then

the marriage enrichment program -- there was one just last week in Sacramento where they basically opened this up and offered this to the units and their family members and couples, husbands and wives, and soldiers and their spouses come to these.

They're basically retreats that assist a couple, a married couple in just developing a more healthy relationship, which is beneficial for couples that are struggling. It's beneficial for couples that are healthy, and it's an opportunity for them to spend some time focusing on issues that will help them learn to relate better with each other and develop a stronger marriage. And, obviously, our soldiers are more happy and content at home, they're more effective and content in the unit, and there's a lot of -- obviously, I don't have to verify that with anybody.

The second one there, Operation Ready Family. and our family resource groups

or family readiness groups, that has just

been a monumental support for our soldiers that are deployed. I don't go a single day without having at least multiple contact with some family assistance contractor somewhere in the state. They are very, very involved. The California National Guard has hired contractors that are full-time paid by -- paid by the National Guard to serve in this capacity to assist and resource and help the family members of soldiers, particularly of soldiers that are deployed overseas.

They are invaluable. They connect constantly with family members who are going through crises at home, assist them in developing Red Cross, assist them in getting assessments and going to the doctors, dealing with a whole host of issues. Child care, you name it, these folks are involved in helping our soldiers out and their family members out. It's a wonderful, wonderful program.

Our department really helps them in

a number of ways, and probably the most notable is we basically serve as their subject matter expert on mental health issues. And that's usually the kind of calls I get: "Hey, I'm sorry to bother you today,

but let me tell you what a situation we're going on with. I went over to so-and so's house, and this is what I saw, and this is what I experienced, and this is what she said, this is what he said. What do you think? What would be a good next step for us to take?"

And that's usually where we will plug in and say, "Well, have you done this, have you done that," and give them some direction and help them to begin to go through a process of doing some assessment. Sometimes that turns into, you know, somebody actually going down -- we've had our fans actually take a soldier's family member down to a local hospital, get them checked into a psychiatric ward and have them be evaluated.

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And it also sends the Red Cross messages overseas, get in touch with commanders so people are aware, you know, that there's legitimate problems and issues that are taking place on the home front and able to connect those with commanders and inform the commanders overseas as to what's taking place here.

The Operation Ready Family is a

fantastic program. They also have a ton of resources on our National Guard website. They actually have their own kind of thumbnail. You click on it and there's just a ton of resources they have accessible for family members. So we have a little help card that we give out very frequently, and we'll meet with family groups and support groups, and that's one of the big areas where we will use to resource our family members. A wonderful, wonderful program.

The Sexual Assault Preventive Program is kind of a -- it's a big program.

It's one of those things that was kind of -- I don't know how the best way to describe it -- it's kind of hidden issues that we weren't really wrestling with and weren't really aware of years ago, but now it's become more prevalent that we understand what's taking place. And our commands have done a wonderful job of putting this issue out in front, of addressing this issue and putting out resources to be able to help people address these kind of issues.

We are very involved in this program in the sense, again, we serve,

primarily, as a mental health resource. And our biggest connection with this program is, is basically in assisting and helping victims. That would be our primary role in this. We do serve in resourcing and helping at times the offenders in getting treatment and moving forward, but our biggest -- probably our biggest place where we're actually involved in this is actually helping

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the victims to move forward and get some help.

Financial Assistance Fund is a wonderful program. As again the last presenter mentioned, the family that was trying to go visit their loved one on a -- for surgery or for treatment. This is one of the things that Financial Assistance Fund covers. California National Guard has a financial assistance fund. I sit on this board as a voting member and as a representative for mental health, and I watch week after week after week as soldiers are able to submit any unmet need that is directly related to deployment. It doesn't matter what it is.

And, for example, when she made

that statement during her presentation, we just sent a family last week. We approved the funds to send an entire family to Fort Carson to go to their spouse's surgery, who is returning from overseas and deployment.

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That fund is available where we have found that maybe there's loopholes, or there's problems, or there's places where family members are not able to get some financial assistance for one reason or another. This fund is just open to any -- and that's the only -- the standard operating procedure if you read the information piece -- the only criteria is that this -- that it has somehow related to the deployment. Any unmet need. It can fit any -- any area of the soldier's life from helping family members fly to Fort Carson, to buying a ramp for their house, which we've done, you know, so the wheelchair can now be pushed up there. All kinds of things, all kinds of issues, we will support that. That's a wonderful, wonderful program.

And again, one of the things that has been beneficial to have mental health representatives on this committee, is a lot of times we will get applications, and when

you read the application itself, you can kind

of assess there -- there may be an issue here. There may be an issue with this soldier, there may be an issue with this family. And a lot of times what they'll do is they'll refer them over to me to do assessments and some evaluations, interact with that family member or that soldier to kind of find out if there's additional issues where we can help from a mental health perspective. And that's been a great -- a great program as well.

Peer To Peer Counseling Program was started, basically, by a police chief in Antioch, California. He used to be a police chief in Davis, and he started this program with California National Guard a couple of years ago. And, basically, the concept is kind of in addition to the critical incident debriefings that we do. It's basically training soldiers in the units that, specifically, we're targeting units that deploy. We're going --we're training them on

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a two-day process where we are basically teaching them active listening and counseling skills, and engaging skills. We're giving them resources, helping connect them to what's available for them to make use of, and then these soldiers go back to their units, and they kind of serve as front line leaders.

They kind of serve as, as the early warning system in those, in those units. Just at a training yesterday in San Diego heading back down south in about a month to do some more down there in El Centro for our folks that are working along the border, and this is a wonderful program because again it helps soldiers to connect with soldiers, and that's company commander.

When I was overseas in Iraq, I knew that there were a lot of soldiers that their first person they talked to when they had issues were the guy that they ride with in the HUMV every day, the person they bunk next to in the tent every night. Those are the

first people they talk to. A lot of times

they're nervous to go up the chain of command because they're scared sometimes the consequences that might take place or might not take place. They don't want to be pulled off the duty, they don't want to have certain things happen to them, so sometimes they'll just share that with somebody else.

That's where this program becomes really, really, really valuable, because that person is trained in understanding and listening and watching for certain signs. We work with a lot of different issues in the peer-to-peer counseling. They go through a lot of just kind of serial training where they sit down and they're actually given a scenario, and they have to work through that. After they've received their certification and their training, they do updates.

This is a wonderful program, and we're again, where we have our hands in it, is when we do a peer-to-peer counseling

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mental health goes, and we'll do a block on suicide prevention; we'll do a block on, you know, chronic stress; we'll do a block on soliciting skills. And that's where we'll be engaged in the process in assisting with the

peer-to-peer counseling program, a fantastic program that helps soldiers basically learn to help each other.

Those are the primary soldiers, the primary programs that we're working with in the state of California to assist and help with mental health problems and issues with our soldiers for both the California Army and the Air National Guard.

My passion, I would like to see us involved in every aspect of what our soldiers should do, and, obviously, again, I want to say thank you to my command, even though I don't have our TAG sitting here in the room. I want to say it publicly that I'm very supportive of our command. They've been wonderful and very, very proactive in

addressing the mental health needs of our soldiers.

I want to say thank you to the Task Force for your efforts and your work traveling around assessing, making a good oversight of what's happening nationally with this, with the mental health issues, and I appreciate your efforts and your time and your research, and wish you the very best in

your endeavors. Thank you very much.

(Applause)

LTG KILEY: Major Fetrow, thank you very much for a very good presentation. I congratulate you on what you're doing here in California.

MAJ FETROW: Thank you, sir.

LTG KILEY: It's really first class. So I think our next --

DR. McCURDY: Would it be --

LTG KILEY: Yes, certainly. I'm sorry, Layton. Of course, please. Any other questions?

DR. McCURDY: I, too, want to commend you for the comprehensiveness of the program and the way you thought it through, and also for your energy and enthusiasm about it.

MAJ FETROW: Thank you.

DR. McCURDY: This morning we met an ex- Guardsman who had come home from a deployment, and this was early on in the war, he told us, and he -- he didn't speak well of the attention that was paid when he got home.

MAJ FETROW: He didn't.

DR. McCURDY: He said people

brushed him off when he had some issues. And he tried to make it known, and I can assure you this was not a shy person.

MAJ FETROW: Sure. Sure.

DR. McCURDY: He spoke up very emphatically, and ultimately he wound up at the San Francisco VA, taken down there by his father-in- law, he said. And I don't know if your program is relatively recent, and is it

been there all along with the -- with the GWAT (?) or -- or what?

MAJ FETROW: Sir, I think it's -- it's kind of the both/and. It started out with the deployment, and then there's a lot of lessons learned along the ways.

What we're doing right now with Health and Welfare Initiative, for example, is addressing that issue, because that's -- we've heard that numbers of times, the soldiers that come home and, unfortunately, commanders are of the same mentality a lot of times that their soldiers are, and you've been overseas for 12 months, you've been deployed for 18 months, you want to get your people home. And so a lot of times they have this -- and you're all familiar with the

redeployment process, the huge checklist that everybody has to go through -- those commanders a lot of times, you know, are kicking to get people out the door and get the doggone thing checked, you know,

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I-don't-need-a-word-we'll-address-it-later-on kind of thing. And that is one of the issues we're trying to address by, you know, going in and becoming a part of that redeployment process.

And so we say, well, hold on a second, you know. This is a legitimate issue this guy's raised. We're looking at his assessment right here. We're going to -- early on we saw those assessments, sir, but we didn't see them until after they were already out of redeployment station. They came to the TAG, we would get them, we would screen them, we'd go, "Whoa, whoa, whoa," we'd find three or four people, then we would send them to a telephonic conference team who would contact that soldier, do some additional screenings. But it's already after the fact.

That's one of the reasons why we want to go to the mobe station now so we can

assess those screenings right there and go,

"You know, you've got this soldier, this soldier, and this soldier with some legitimate issues that we'd like to do a second screening so we can follow up to make sure there isn't really an issue here." And that's kind of where we're learning along the process to try to assist with that.

Does that address your question?

DR. McCURDY: It does.

MAJ FETROW: Okay. Yes, ma'am?

COL PEREIRA: This morning we were at the San Francisco VA, and one of the issues that we've been looking at at a Task Force, as a Task Force, is greater communication and cooperation between National Guard active-duty reservists and the VA system.

MAJ FETROW: Um-hmm.

COL PEREIRA: They were very adamant about the fact that they would love to be involved with the results of the screening process. They would like to be

informed when there are soldiers identified with issues.

Do you see any way that that might come about and, if so, how would you see that happening?

MAJ FETROW: There is -- I mean, obviously, there's a lot of landmines in that process as far as just sharing confidential information right off the bat that jump out at me.

There is a very definitive issue there, communication, and agree with you, ma'am, and agree with their assessment. We wrestle with it, the Reserves wrestle with it, the Acts deponent wrestles with it, the VA wrestles with it, Tri-West wrestles with it. The chain, the communication chain, sometimes is not real fluid.

As far as providing the VA with the assessment data, I'd have to do some further research, because I said right off the bat there are a number of things jump out at me

as far as sharing confidential information

with -- with the Veterans Administration. I'm not sure what the legalities of that would be, so I'd probably have to sit down with out JAG and find out if that's something that even would be -- would be feasible for us to do.

But we're definitely open to entering into any kind of discussion with the Veteran Administration or any other entity to try to help soldiers in the best and for their best welfare.

COL PEREIRA: Of course, and I realize that we are dealing with a confidentiality issue. But if it were with the agreement--

MAJ FETROW: Sure.

COL PEREIRA: -- of the service member --

MAJ FETROW: Sure.

COL PEREIRA: -- I'm sure that there would be some kind of bridge that you

could build with the VA to try to get that soldier to assistance more readily.

MAJ FETROW: I think that's a legitimate -- it's a legitimate suggestion maybe even to draft a -- some kind of

informed consent or release form that maybe could be done at the redeployment screening that might would be able to assist us in connecting. There's an additional facet for us that would be helpful as well, as if I have a soldier in Modesto and there's a VA center there in Modesto, it would be great if you were able to give that information and share it with the VA with that soldier's permission. It would also be great if I've got a mental health provider, an imbedded mental health provider in Modesto, to let them know, "Hey, here's the situation you have coming back from overseas."

So I think the big thing would probably be the release form and figuring out the legalities of how that would be. I will

definitely look into that. That's a great point. Thank you, ma'am.

Yes, sir?

DR. McCORMICK: Understandably, most -- as I understand it, most of your services are unit- based. What about the National Guardsman who leaves the military right after deployment or soon after deployment? Do you have any kind of outreach

or follow-up to see how they're doing?

MAJ FETROW: Well, sir, again it depends on where they're screened at. If they're screened as -- as have -- if they receive screening from their redeployment posthealth assessment that's negative, yes, we will track them to completion even if they get out. In other words, we have soldiers that are on my database right now that are no longer in the National Guard, but when they came home for redeployment, we started putting them into some additional services, connected them with the vet center or

whatever their treatment plan was, and we will continue to track that to completion to the best of our ability.

Sometimes the soldiers, themselves, get -- and one of the problems again in the National Guard Reserves, specifically, the soldier will come home for redeployment, they'll get out of the Service, and then they'll move and not provide any forwarding information to the National Guard or to their unit, and we don't even know how to find them, then, at that point. And it becomes, you know, it becomes a logistical issue as

well.

Yes, sir?

COL ORMAN: First I want to commend you on all your programs, particularly your Imbedded Behavioral Health Program. One of the things I saw that was sort of absent, so I didn't see it up there, was this whole business of the Military One Source. Do you all not market that? Or --

CAPT McKEATHERN: Oh, that's -- we use that and that's a great point. That goes across almost every one of our programs. Our Family Readiness Group just this last week, for example, when I met with the Family Readiness Group contractor, and I put a whole table out of One Source stuff. And as I was setting it out there, she walked up to me and said, "We put that same table out every month. They're very aware of it." We have these cards out. It goes through Family Readiness Group. We put it out all the time.

The Marriage Enrichment stuff just last weekend put it out. Almost all of our entities within the National Guard are constantly pumping the Military One Source, great resources there, sir.

COL ORMAN: And the other thing I want to comment the state on is this whole business of hiring you full time. Maybe we could do this as a sidebar afterwards, but do you keep in touch with your counterparts in

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other states that have an equivalent position?

MAJ FETROW: Well, sir, that's definitely on my short list of things to do. I've only been in this position for two months --

COL ORMAN: Sure.

MAJ FETROW: -- so I wanted to get my hands around all the programs first and make sure we're taking care of soldiers here. And then, definitely, that's -- that would be -- and again I think that will be one of the benefits of having this program across state lines because we would definitely learn from each other. I'd love to be able to call somebody else and say, "What are you -- what are you getting? What's happening in your area? What are some things we could do better?" And meet with those folks and find out what, where we're missing things. That would be a wonderful, wonderful addition.

Yes, sir?

COL CAMPISE: In your Operation We Care, how successful are you at engaging the families that are distant from the unit? And then what specific services do you offer them?

MAJ FETROW: The We Care director that I spoke with just this last week said that, traditionally, they have about 30 percent attendance from, from their groups that will actually show up at their meetings.

It's -- it's a tough target because, unfortunately, we do not have the resources to, you know, put a We Care meeting in every, you know, city across the state. So we target Sacramento. I believe she was saying her region is, you know, still about an hour-and-a-half drive. So there's still some people that would fit in her reason that an hour and a half is a long way, and especially if you're trying to drive from San Francisco or going through some of the traffic around here.

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So we're trying to make that as small of a window as we can possibly make it, but right now we're seeing about 30 percent response to that.

LTG KILEY: A question back here.

MAJ FETROW: Yes, ma'am?

SPEAKER: Major Fetrow, who -- I'm -- your Air National Guard -- (off mike)-- person.

MAJ FETROW: Outstanding.

SPEAKER: I wanted to let you know that our unit, the 129th Rescue Wing (?) is also a pilot program for (off mike).

MAJ FETROW: Great. Fantastic.

SPEAKER: I wanted to address the Colonel here about Operation Care. I am also your Bay Area Operation Care Family Assistant Coordinator.

MAJ FETROW: Fantastic.

SPEAKER: It is tough getting our families out to this Bay Area.

Our Operation We Care meetings is

actually held at -- (off mike). What I have

found in the last five years, sir, is that here in the Bay Area -- and I think the total residents understand this -- we have to -- most of our families are two-income families. They're commuting. At the end of their long day they have to squeeze whatever time they have to spend family time together. The prospects of volunteering to be part of the Family Readiness Program, the prospect of going to Harper (?) Field, for example, for a meeting, it's a tough -- it's a tough sell.

I mean I compete regularly with the notion of leaving home once you get there, because -- I'm ashamed of myself and --

So anyway, I -- I'd like to say that one of the things that came up for me this past year was, I've known that we deploy a combat stress team to SRTs. (off mike)-- recently at the Operation -- (off mike)-- Family Readiness course is the idea of having a team of not so much casualty assistance

post, but family readiness-related team to kind of be there with the family.

To expand on that thought would be the notion of having a team that deploys, once they notice a service member is injured

-- and I have a great relationship with the hospital at Palo Alto.

Our relationship with a military base on it, with a -- (off mike)-- severe injury operation guys. So that helps, but it denies if our -- (off mike)-- local area unit Family Readiness Program would be to help with the families.

I understand the patients at the VA Hospital, the injured soldiers do work with the social worker, and the family members work closely with the social worker to get their needs met in (off mike). We've introduced ourselves. We've explained our program what we do, and we've even further enhanced our networking resources in the area.

But you heard Kerry Childress say earlier that, you know, families are another casualty. So who is it they get deploying them, to reach them? So that would be something -- and I agree General Wade is a great TAG, and I think that he deals in soliciting this -- listening to this recommendation, and if you'll take that back to him, sir, you're welcome.

LTG KILEY: Okay, Major Fetrow, thank you very much for a great presentation. The best of luck to you. Keep up the good work, as they say.

MAJ FETROW: Thank you.

LTG KILEY: Yeah?

SPEAKER: I had some questions for the Major.

LTG KILEY: Okay, well, I've got another presentation. If you want to go catch him in the hallway, go ahead.

SPEAKER: Well, I wanted to get it on the record, but that's --

LTG KILEY: Well, will someone go get him?

(Pause)

LTG KILEY: Somebody else had a question for you.

SPEAKER: Just a few more, sir. Matthew Heddessy (?).

You mentioned that you have civilian mental health providers imbedded with your armories, and my question is what percentage of your service members and Guard members have actually requested care through these individuals.

MAJ FETROW: I would hesitate to provide an exact statistic on that. I would have to give it to the Tri-West representative who manages the program. It would vary from armory to armory.

What we have discovered is a lot of times their willingness to involve with the mental health professional is, one, deployment related. For example, we've had a

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couple of units that have suffered a lot of casualties and had a lot of issues to take place while they were overseas. We've found them to be more -- more apt to make use of their mental health assets that are on site whereas opposed to units who in their deployment had very little kind of activity, that they tend to be a little more difficult.

And I think the second issue has been the duration of the provider. We've already definitely demonstrated that the longer that provider is around and connected with the unit, the more exposure the provider has to -- given by the command, the more apt the soldiers are to use that person as a resource.

And when you're on ground for the

first time as a new provider, the first couple of months can be pretty rough. There's suspicion, there's, you know, mistrust. It's all the cynicism that we have in our society anyway, you'll might be a

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little hesitant to go. There's still a stigma of getting mental health assist- -- getting mental health assistance, so the first couple of months could be a little bit rough, but there are a lot of variables to the level of involvement that our soldiers will connect with our mental health providers.

SPEAKER: Can you extract that data and provide it to the Task Force?

MAJ FETROW: Sure I could, yes.

SPEAKER: One other question is, you mentioned the term "mental health representative." Can you define that?

MAJ FETROW: What did I refer that to?

SPEAKER: You used the term "mental health representative."

MAJ FETROW: Any of our programs within the state of California, anybody that we will put in a position -- for example, if

you're referring to imbedded mental health

program, they have to be a licensed professional in the State of California.

SPEAKER: You all do -- you used two terms. One was the imbedded person that has to go through the licensing and all that.

And then you used a different term "mental health representative." And I was wondering if you could define that.

MAJ FETROW: We may use a representative that's not doing a clinical or therapeutic work, that might be doing something under the umbrella of mental health, sitting at the SRP, for example, and setting up our tables, and collecting data, and working things on the computer that they're not clinicians, they're not licensed, but they're still a representative of the mental health programs. They work for mental health, but they're not a provider or a clinician.

SPEAKER: Would that be like a collateral duty for a typical soldier?

89

MAJ FETROW: Correct, yes.
SPEAKER: Okay. And then you also used the term "limited counseling." What does that mean, "limited counseling"?
MAJ FETROW: Most of what -- you're referring to what I referred to as Joint Forces Headquarters?
SPEAKER: I don't know. You were mentioning about different levels of care that --
MAJ FETROW: I was referring, specifically, at that point to what we offer right now at Joint Forces Headquarters, and just by the nature of my travels and by the time that I'm not available in the building, I was referring mostly to myself, as I provide limited counseling services because I'm just -- I'm not a full-time clinician sitting there in an office taking a full-time schedule. I will take a limited -- limited number of folks that I can personally work with.

90

Others, they get referred. If I --

I will never -- and I don't think anybody would -- that we never turn a soldier away. If I don't have, personally, have time to deal with somebody who's in Sacramento, for example, and I can't bring them onto my schedule that fits them and myself, I will find a reference for them. I'll find somebody to connect them to, to where they can get some help.

SPEAKER: And then how many Guard members who have received referrals to a psychologist or psychiatrist, do you have that data?

MAJ FETROW: How many have in specific numbers?

SPEAKER: Yes, in California National Guard.

MAJ FETROW: Our last information paper has the data. I don't have it with me. I can extract that data as well and provide that to the Task Force.

SPEAKER: Um-hmm, and then how many National Guard members, California National Guard members, are currently being prescribed mental health drugs such as antianxiety, sleep aids, or SSRIs?

MAJ FETROW: I'm not sure how easy that's going to be to track, again for confidentiality issues.

SPEAKER: Well, you wouldn't have to identify anybody by name, but just --

MAJ FETROW: I'd -- I'd have to do some research.

SPEAKER: -- to get some data on that would be interesting to know for the purposes of the Task Force, I believe.

And then you also mentioned something about the Sacramento Bee and some statistics of service members coming forward, and I wasn't quite clear on what your point was. Can you clarify that?

MAJ FETROW: Repeat it?

SPEAKER: When you opened your

initial comment related to an article in the Sacramento Bee, and you mentioned something about the statistics that were printed in an article. And I wasn't quite sure what you were getting at. It was a little ambiguous. Could you please clarify?

MAJ FETROW: My only statement is that it's not my purpose to -- it's not my purpose or my task here today or within my

field of expertise to debate with the Sacramento Bee or any other entity what the actual statistics of PTSD or stress-related combat illness is. It's not my purpose. I used the article to illustrate the fact that it is an issue. It is an issue that has gained public attention; it is an issue that we are looking at, are aware of. What those actual statistics are, that's not my place to debate, and so I'm not questioning --

SPEAKER: So you weren't -- you weren't arguing. You were not arguing that those were not correct?

MAJ FETROW: No, I'm not questioning the validity of that article --

SPEAKER: I just didn't -- that wasn't clear to me.

MAJ FETROW: -- one way or the other.

SPEAKER: And then how many --

LTG KILEY: We'll take one more question from you, okay? And then we'll have somebody next to present.

SPEAKER: How many Guard members who have been treated or provided care by a mental health care provider or are currently

under mental health care provider's kind of watch, how many of those have been discharged prior to completing their obligated service?

MAJ FETROW: Again that would be data I don't have on my head. I'd have to -- I'd have to extract that to provide that to the Task Force.

SPEAKER: Okay, thank you, sir.

LTG KILEY: Okay, thank you. Thank

you, Major. That's good work.

Okay the next presenters are Lt. Colonel David Canoll -- I hope I pronounced that properly.

LTC CANOLL: Yes, sir.

LTG KILEY: And Colonel Andre Henry from the Reserves to talk to us a little bit about Reserve programs.

COL HENRY: Good afternoon, ladies and gentlemen. I am Dr. Henry. I am the command surgeon for the 63rd RRC in California, for the State of California --

SPEAKER: Could you use the microphone, please, we can't hear you back here. Thank you.

(Pause.)

COL HENRY: Sorry. I'm Colonel

Henry. I'm the Common Surgeon for the 63rd Regional Readiness Command in California. We are situated in Los Alamitos some 25 miles from the City of Los Angeles. We cover the state of California, the state

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of Arizona, and the state of Nevada. Currently, we have assigned 8,700 soldiers. Of this number of soldiers, 7000 were -- more than 7,000 will be deployed and come back. We still have some soldiers in the theater at this time.

Our goal is to provide a seamless transition and continuum of care from the time of the deployment to the time that the soldier is reintegrated in society. The first step is identification. One of the most difficult situations that we have in the Reserve is to get the soldier and family to learn how is the presentation of the different condition that affect the behavior of the soldier when he come back. You are looking at two different scale.

On one hand, on the active duty model, you have a group of soldier who live in the same place, participating of the same activity. They are almost confine, and when

22 something happen there are someone that they

1 can talk to, as compared to, geographically,
2 dispersed member of soldier in -- (off
3 mike)-- state like California and Nevada,
4 that you have to reach -- they have to be
5 able to reach you when something happen.
6 When they get the assessment of --
7 the postdeployment assessment, the first
8 assessment, at that time you know better than
9 me I've-been-there- I-know-how-it-feels. You
10 are in a hurry to go home. They try to
11 explain to you 10, 12, 20 different plan
12 things that you have to do starting with the
13 VA, starting with TRICARE going on. You
14 don't listen to them. You are looking at
15 your watch. You are concern at what time is
16 my next plane to go home. "I've been out for
17 six months, for one year, this is not the
18 time to try to educate me on all the
19 resources that are available to me to take
20 care of problem, one.
21 "Two. On how I supposed to learn
22 how to identify this problem?" So the first

assessment is really psychologically -- I cannot talk about psychology, but common sense will tell you, if you are unaware, you are going home, you may hear but you don't listen, and you don't comprehend.

So the identification is a part of being able to identify your condition, is a part of education and knowledge, education that you receive and education is, by definition, repetition. If you heard it one time, you don't know it yet no matter how smart you are.

So this soldier come back, go over there where he live, isolated from the rest of the people. He forget what the -- he forgot all about, oh, sleep disturbance, aggressivity, depression. He does not know what is going on, and the only thing he knows is his wife say, "Hey, you have changed a lot, what is going on with you?"

If we could establish a system whereby this soldier could be contacted again

and refresh his memory about the

manifestation of this condition, give him some point to say, hey, if you feel this, if you feel that, you need to look for help. Maybe it's nothing, but maybe something.

I remember two things -- (off mike). I went to have an evening dinner with the family, we are related. And here I was able to welcome Montess (?). Montess was just coming back from Iraq. Montess was all excited, and I said, "Montess, how are you doing?"

He say, "I am doing great. I had problem with my knee and I was on Med Hold, and they fix it. I have problem with my shoulder, I was on Med Hall and they fix it."

I say, "You are doing okay? Everything is doing okay?"

"Oh, yes. Yes, yes." We have dinner, and when you -- you have the impression there is something else, someone want to tell you something. And so then the

mother say, "Do you have a minute, can I talk to you?" So she took me to another room, and she say, "Montess is having problem."

I say, "What type of problem? I just talked to him."

"Yes. He cannot sleep. He wake up at night and he is fighting, and he's being aggressive. He's not the same Montess that I knew before deployment."

I say, "Yes, how long has this been going on?"

"He has been getting more and more frequent. He's getting worse. Is there anything that can be done for him?"

I thank God for the opportunity to help. If I was not educated, I would have sit down like them and continue complaining. I was able to tell him yes, there are military program, and I give him the leads -- I give her the leads. I tell her from One Source, I tell her about the Veteran Administration. I'm happy to tell you that

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Montess went to the VA, and he was treated there. And today Montess is an active member of society. He has a job, he live with his family, and he is thankful because someone was able to say identification is the first issue.

It's difficult. Identification has another difficulty, mainly in California, you can tell by my pronunciation. Even many

people language, theater, plays -- well, if you don't speak the language, it's very difficult to accept the people. Family, the people living around the soldier are the first one to observe the change. If you cannot talk to them, how can you help him?

So the education is not only the education of the soldier but is education of the family who live around the soldier. In order to do it -- there are immigrant, you have to be able to speak their language, and this is more prevalent in California than some other states that the family -- that we

should be able to identify people who speak the language of the family so they can contact them, educate them, and tell them these are the element you have to look for, when you see them, you know that he needs help. And provide it.

So we are still talking about the education of the provider. Most of the provider will live in isolated place where there are very few military units, don't know about the psychological or psychiatric manifestation. They don't know about posttraumatic disorder. They need to

befriend so they can also help identifying the problem. So for us we fell in a disparate geographical -- a geographic scenario. We have problem with educating the soldier, we have problem with educating the family, we have problem contacting the family in their own language, and we have a problem of educating the provider so they can make early identification of any mental condition

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that need assessment.

There's a one step is access. Access become even more complicated when you have multiple alternative. It's like you're standing in front of a -- (off mike)-- you don't know if to go to the right, to go to the left, or you remember vaguely that they told him, oh, you have TRICARE-West, you have Veteran Administration, you have One Source, you have a number of program that are available to you. But how will you access the program?

Most of the program -- and I don't know if you have experience -- are not that customer- friendly. You know, you pick up the phone and call -- "Oh, I don't know. You should call -- you should talk to Vet. We

have a call -- (off mike)-- there. I can give you this phone number." People become frustrated.

They don't want to go through this repetitious thing. Oh, my, my, when 50

minutes and I turn to my wife, I say, "I was on the phone for 30 minutes. They were not able to help me. I'm worse than what I was before. Whom shall I call?"

Access is very difficult. It is not only difficult in big city like the Los Angeles that you can walk to the VA and ask who is in charge of mental health, so someone will direct you. But imagine the very small city, you know, where you have very few health care facility. And even if you go to the VA, even if you go to TRICARE-West, the first thing they will ask you for your Social Security, they will put it in the computer. Guess what. You are not in there, there is nothing we can do for you.

Have you heard that before? I have heard it. Soldier come all the time to my office saying, "You know, I went to the VA. I feel we even have one more -- (off mike)." He went to the VA, he was not in there, he

was not accepted. So access is a very big

issue. You may have the education, you may identify the condition, but if you don't have access to the resources you have nothing.

And I may say something that is related by -- (off mike). You know, there are so many door, people get more confused. I would prefer to have one or two resources that people understand fully and they know: If I go to Door A, someone will listen to me and will guide me on what to do.

Sometime we feel better giving a long laundry list of all the things that you have available. The person walk out and say, "Which one? Which one shall I go to? Which one I am eligible for?" Because besides going to the place, you have to be eligible to receive the services of that place, and if you are not eligible in that place, they will not send you to the one they believe you are eligible to, because they don't know.

You know, "I just know my part of the story, I know you don't belong to here.

105

This is all what I can do. Maybe you should go back to your unit and ask them."

One of the problem we have with access is the unit. We need to get more education to our unit administrator so they know about what is the step. And the reason they don't know is the system is so complicated, have so many element, and this is one of the things they do out of a number of things.

So really, if maybe we have few well- consolidated that we can educate the soldier about so he know when he had the problem he can go to the unit, the unit will know what to do. If it is difficult to the soldier to have the access, you imagine how difficult it is for the family to have access.

Most all of our soldiers speak English. Many of our family don't speak English, so when they go to these big institutions, so they are intimidated then.

106

Wow, where shall I go first? You know, and

second, they get to someone who is not sensitive to their lack of knowledge of the language, and they don't receive the information very well, because family also is affected by deployment. Family also need help and assistance.

If they cannot access it, we are out of it. The third element, when you access after you find a place that want to receive you, is the treatment. We don't have major problem with the treatment because treatment are generally provided by highly-qualified provider, and when the soldier is in the system, he will find his way around, so we don't have that major problem with the treatment.

Where we do have a problem is sometimes the soldier receive a bill at home. Soldier receive bill, and they bring it to my office and say, "What shall I do with this bill?"

And we say, "Wait a minute. We are going to take care of it. Give us a copy. This probably has been a mistake. We will contact the different -- (off mike)-- and get taking care of." But this is something that

make people scared, intimidate them, and you know how each type of news travel fast, you know. One soldier receive a bill, he tell everybody, all of them don't want to go because they are afraid of receiving the bill.

But I believe we have this under control, and we always tell them when I refer a soldier to one of the faculty, I always tell him, "You may receive a bill by mistake. If you receive a bill, please bring it back to my office," so people don't fear so, it so.

When they get the treatment, and the treatment is successful, we go to the transition period where this no-longer-a-patient is making slowly his way

toward getting again active in society. Condition is a -- (off mike)-- because the soldier still needs support. Soldier still needs people who understand their problem and still need access in case of recurrence. Because many time we give them the problem for resolve, but when they are on their own feet, and they feel the weakness of the knee, and if you have the timely assistance at that

time, you may present having to give a full range of treatment again. So during that condition period, the support is chief.

Sometime when the soldier live isolated in a very far city, it is difficult to provide the assistance and support that they need doing. So this is one of the problem that we see, during this period, of condition.

And, finally, condition is perfect, soldier is fully re-establish or rehabilitated, and we get him back in society. He has a job, he is with -- he has

a family, everybody is happy do our job, and there -- no. We still need the follow-up.

That is the last step. The follow-up, it does not need to be every week. If he has someone to give him a call to find out, so he find out that we still care about him, "How things are doing, Joe? Good? You have a job?" You know, this type of follow-up to provide the soldier.

I want to make a couple of observation without being resisted (?). The postdeployment, I want to make an observation on that. The postdeployment window, that is

90 days to 150 days. Some of the studies published by Dr. Hoge of Walter Reed Hospital shows the maximum incidence of behavior problem happen at two months. So if we open the window at three, we may miss some of these people early, and when they don't get into our system, they go into the civilian system, and they get lost, and they get more confused. Maybe this reassessment

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should be pushed back more so it can impact the soldier, because most of the behavioral problem happen in the two-month window. So within two months, get it back.

The second issue I want to comment is HIPAA. HIPAA -- I don't know if everybody know what HIPAA is. HIPAA the laws that regulate the transfer of medical records and protect their confidentiality. Once the soldier go to a civilian place, it is very difficult to get that record back, and the record is chief to know what has been going on in the past and what treatment, if any, he has received, so what manifestation of the disease from the beginning.

So we get involved in this and we get stopped there, we cannot get all the

records, and it become -- even sometime from some military treatment facility we have problem in getting the record when we need the soldier to be assess or to be exam, or whatever. So this is an issue, also.

One thing we have learned that help us a lot is chaplain. Chaplain not only help us in the societal soldier that chaplain is able to go and talk to them and find out -- because, you know, we find from a third person that Joe had some thought, so now we definitely use our chaplain because they are all over the different states. They can go and visit Joe, have a conversation with Joe, get back to earth, or send Joe, tell Joe, "Hey, you better go to emergency room." Of most of the cases, 95 out of 100, they will be negative. There is no relative, but at least we have someone who have contacted the soldier, have talked to them, they are trained in identifying this stuff, so they are -- they are good and, you know, and they continue that relationship with Joe, so he has either two-prong: Either identification prong, either a support prong because a chaplain continue maintaining that

relationship.

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Families within this program we have, we believe in the strong family within this program. We believe that with this program where the soldier family can go and get the support that they need and talk to people what been through this before, willing to listen to them, they get good advice, and they -- many times they believe in them more than what they believe other people, because they have been there.

This is more or less some of the handicap and difficulty that we have found in implementing this mental health program to our soldiers. And implementing also the postdeployment reassessment program adequately. I don't think there is any questions. Yes?

COL ORMAN: First of all, sir, thank you very much. I thought that was a great presentation.

COL HENRY: Thank you.

COL ORMAN: We're going to write a

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report that goes to the Secretary of Defense and ultimately to Congress. If you had to pick two, three, or four things that would go in that report that would be helpful for you to achieve all these goals which you're sort of outlined for us, what would those sorts of things be in a concrete, specific sort of way?

COL HENRY: Ah, a difficulty question, but first I will start by saying the Reserve, Reserve component or the Guard, either geographically distant as compared to the Active- Duty with a captive audience. From the dispersion of the Reserve component comes a number of complication in order to be there to educate them on how to recognize the condition; to give them the appropriate information on how to access the system; and probably focus more the resources on a couple of them than so many that people get lost and don't know where to turn.

COL ORMAN: Let me give you an

example of what I kind of had in mind. You

outlined the problems extremely well, but the nature of the problem is complex, as you know. And so it strikes me, for instance, the National Guard has their own mental health director for the state. Do you need something like a mental health director to help you organize solving some of these problems that you have?

COL HENRY: I believe the problem is not resources. We have too many resources. We have One Source, we have the Veteran Administration, we have TRICARE-West, we have military treatments facility. All of them have very qualified professionals that can provide the care. Our issue is many people know that difficulties exist, and when they know, how will they get to them?

LTC CANOLL: Sir, one of the challenges on that micro- --(off mike)-- that you're talking about, within our own office and, as you know, transition is occurring and

we're going to be growing -- we're going to be growing in size -- is that we don't have a mental health specialist on the staff. And it would be good.

And when we were -- owned the

medical units which about 18 months ago transitioned, we lost a tremendous resource in me being able to detail people up to assist with those SRPs and stuff. Now, we have developed relationships, and we have a very good working relationships, but mental health resources are scarce, and so we don't have them like the Guard does or the Active component does at all of our functions.

Another way we're trying to impact those challenges is to mandate -- or not mandate but to encourage -- the command programs to bring the families in. So when we bring in those subject matter, expertise from One Source, or if we have an Air Med Com asset, they can address the families as well, because a lot of the issues that are going on

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-- that at least have come across my desk as a full-timer -- not necessarily are for the soldier but for the families.

So, specifically, yes, we need to look at the staffing pattern, maybe not for the RRCs, since, as a function they are going away for the RRSCs and relook what the RRSCs and what the functional commands are going to have, and really hone in on those O and Fs

for those two agencies, to say, okay, who is going to have that belt buckle, that Social Security number action to make sure that these soldiers are not only coming back and having the resources that they need, but the soldiers and the family have been going out the door. And how are we going to include all these various resources to make sure that's done.

You know, everyone can say it's done on family days, it's done at SRPs and everything else, but we all know the reality is 10, 20 percent of the families participate

in that. So that's one of the challenges, sir.

COL HENRY: We have been looking for a psychiatrist to become a member of the Surgeon Office to guide us. We used to have one, and he retired. And we have been looking for one. The unit who owned them will go to war if they lose them. So it is very difficult, but we have recognized the need for one of them. Yes, another question?

(No response.)

Thank you very much. I appreciate the --

(Applause)

COL HENRY: I appreciate the privilege to participate in this type of Task Force, and I recognize your dedication, and I know we will learn and we will profit of them. Thank you very much.

LTG KILEY: Thank you, Doctor. You're done, and that appears to end the formal presentations. I think we're now

going to open this up for public comment, if anyone in the audience has an interest to address and comment to the Task Force, we'd ask you that you just step up to the microphone, introduce yourself and say what your concern or issues are.

AUDIENCE MEMBER ZANIKA: My name's Mary Zanika (?). I'm the wife of a -- I've been married to a Vietnam veteran, a Silver Star decorated staff sergeant over there -- for 33 years. And not only he has suffered PTSD but I have and my family. And the reason that I'm here today is I've heard -- and you're the experts right here -- of studies that they have done with EMDR, eye movement desensitization response.

I believe they did a -- they

treated PTSD, and I think it's in the state -- Washington, Washington state, where they have had success in treating PTSD, so my question to you is, is that available? Is that something that's going to be available

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so that, you know, to help, you know, those veterans that suffer, you know -- it's -- you know, I don't have to explain to you because you all know what PTSD is. I'm here to see if I can get help, okay, and so is it going to be available anywhere locally? Thank you.

LTG KILEY: Do you want to take that or--

DR. ZEISS: I appreciate that you are interested in the evidence to support treatments for PTSD because, certainly, I want to underscore the real value of getting treatment that has been used in a research context that really we know can be effective.

And you've heard about EMDR, and that there is a small amount of research that supports EMDR in terms of its potential for positive outcomes, but not in terms of it really working for the reasons that the people who developed that treatment thought it might work. And the essential component

of EMDR seems to be a careful exposure in a

context in which people can do new learning and new experiencing in the presence of a sensitive therapist who can really guide that process.

There are other therapies that have better outcomes, better research. Cognitive processing therapy and prolonged exposure are two that we're particularly interested in, in the Department of Veterans Affairs. And I can tell you that both VA Palo Alto and San Francisco VA where we visited they are using those approaches, and this training and opportunity to use them will be expanding quite a bit over the next year, if not even sooner.

So I really encourage you to look for what are the best evidence-based therapies available. I only know about the Department of Veterans Affairs context. I can say that there are good treatments available there, and I don't know about within the TRICARE system, for instance, or

other contexts. Perhaps other in the audience or others other here might.

LTG KILEY: Thank you, Dr. Zeiss, that's a very good answer. The only other thing I would add is we've certainly taken a note, and we can investigate that. I would be very hesitant -- in fact, I won't predict and project what the Task Force will be reporting on and making recommendations on yet. We're still very early in the deliberation process, and I really would be -- it would be inappropriate for us to start articulating things that we're going to recommend or that we think should be done.

But we can certainly --I've made a note, and we can certainly do some further research on that.

Yes, ma'am?

AUDIENCE MEMBER WALKER: Hi, my name's Reed Walker. I'm the Women's Program Coordinator at Sacramento Veterans Resource Center. We're part of the Vietnam Veterans

of California.

One of the concerns that we have and I can speak to, personally. I'm a medically-retired disabled veteran, and one of the issues that we come up with in our work with homeless and drug- addicted veterans is that many times these problems are of a longstanding nature. They were in Vietnam or some other place, and they weren't able because of the PTSD and sometimes the issues that they had with military life in general to approach the VA or come through a military system itself.

And so we'd like to recommend that, especially with the Guard and the Reserve being so dispersed the way it is, that the Department of Defense look at being able to contract perhaps with organizations like ours or faith-based organizations to provide some of this care.

We provide therapy at our site. We have two therapists, and we do it on a pro

bono basis because we don't have any mental health care contracts. We do it through the Veterans Administration grant per diem program. So that's a thought that I wanted to share with you.

LTG KILEY: Thank you very much. That's a very interesting insight.

AUDIENCE MEMBER SGT STEWART: Serge ant Noell W. Stewart, Retired, Al-Jibal, Desert Storm. I'm a recovering alcoholic, two years of sobriety. Did I have posttraumatic stress syndrome? I should be a quadriplegic. I'm walking. I thank God for this country because without the VA system and the system that the World War I veterans fought for and the Spanish American War veterans brought forth, we have you here now.

However, my concern as a Desert Storm veteran is that these men are 52 percent Reservist and National Guard. When I came back, we were supposed to land at Fort Jackson; we landed at Fort Dix. All we

wanted to do is go home. We didn't know that the other things would happen to us, the Desert Storm syndrome. I was one of the first 60 that applied for it. It took us almost eight years.

Eight years is too long. These men that are going to come back are probably not going to want to be a part of the United States Army or want to be a part of the

Reserves. They're going to be out in the general public. Right now what has served in this was is 1.5 million people have gone to this war. Four hundred and fifty thousand of them will, eventually, or may have posttraumatic syndrome. This is a big number. It's not small.

Most of these men will come back. I am tried of everyone saying this is Vietnam. This is not Vietnam; this is a far different situation. These people that we are dealing with in Iraq have a total different outlook than we do.

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This isn't Korea. The only letter I got from my father is, don't trust the natives. I guess that's what we're coming back and hearing most of these men saying, don't trust the natives.

We now have men that are being tried for crimes that perhaps they would never have committed in the United States.

We all know, as military men, we're under check. I didn't drink. Eventually, I did start drinking for 10 years. Eventually, it was a half a bottle of wine that stopped me from drinking anymore. I've been getting

my life together. I've lived on the river, I'm a good scientist, a good architect, but I lost my life, and finally I got it back.

The VA, thank God for them and thank God for my benefits. Thank God that I have military training to get me back on my own feet. I would hope that this panel would recommend, all because a man gets out of the Service, it's going to be hard to find the

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Veterans Administration. It's very difficult, very difficult because now the veterans' service, they're taking care of the World War II veterans, the Korean veterans, the Vietnam veterans, and sometimes us Desert Storm veterans. These men are going to come back wanting treatment.

It's very well and good to talk about different philosophies, different viewpoints. But the thing is that we're going to have to get these 450,000 potential people into the system. Let's not let them go. Let's not let eight years pass. Let's not have these men turn into alcoholics and drug addicts because of the things they've seen or done.

I saw terrific things myself.

Perhaps I should have been in the barracks where 150 men were killed. I was freezing my ass off in the Gulf War with no ammunition. I served in the port city of Al Jibal, where 15 scud attacks occurred. It was horrific.

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I don't know what these men are like. I've met them at airports, I've talked to at least 150 of them to try to get a viewpoint. I've traveled five and a half hours and I am a little bit late. Usually, Sergeant Stewart was never late. He made sure the port worked well.

The Army is the best service in the world. They can do the job that no one else can. The VA, given the direction, they can do the job. I only ask that we do not abandon these men. Even though they get out of the Service, we take them in our arms, we don't allow them to become the bonus army of World War I. We don't allow them to become the Desert Storm veterans. They are our men. They are our men. They are stood on the parapets as we have stood on the parapets.

It does not matter that we are just citizens. We cannot disagree with this war. We are here, those men are there. We can do

the job.

We are a country that is great, we can do the job, and I know that you men and women can take my opinion and at least do a better job, because the Army can do.

And I thank you for your time and your patience, and God bless.

LTG KILEY: Thank you very much. God bless you, too.

(Applause)

AUDIENCE MEMBER DR. WRESSLER: Good afternoon. My name is Dr. Ann Wressler (?).

I'm an Assistant Professor of Public Health at San Jose State University, and I come before you today wearing two hats: The first is as the mother of a veteran who has served three deployments to Iraq for a total of two years. The other is as a researcher working with returning Iraq war veterans, looking at what the issues are particularly around mental health that they're dealing with. And I'd just like to say that I know that there's been a lot of

conversation about the services that are in place, but from my findings there aren't enough services, and I'd like to go through a few of them just very briefly.

What I'm finding in the focus groups and in the one-on-one conversations that I'm having with both Iraq war vets and families, is an incredible increase in risk-taking behavior and violent behavior; an increase in motor vehicle and motorcycle injuries and subsequent death from them; an increase in substance use, including on bases, by the way -- alcohol, marijuana, cocaine, and Ecstasy; increased domestic violence and divorce rates; men sleeping with weapons under their pillows, on their nightstands, driving around with them in their vehicles which causes potential concern for children and the partners that they live with.

Many of these soldiers you talked about, the screening form that they have to

fill out when they come home, many of them

are not willing to fill that form out and identify that they have any issues because they just want to get home. They just want to be with their families after having been in, in-country for, you know, six months to a year. They're oftentimes put under a lot of pressure to not fill out those forms from the units because the unit members want to get home.

The treatments that they're receiving in the field is inappropriate, and I think in some cases absolutely appalling, putting soldiers who are suffering from posttraumatic stress disorder on antipsychotics and keeping them in a war zone is absolutely criminal. Classifying soldiers who are suffering with TPSD, with personality disorders instead of giving them their true diagnosis is not going to do anything to help them or their families; dismissing the role of war or trauma and mental health disorders;

telling families and some of the veterans that some of the issues would not have occurred without the -- that the issues would have occurred without the war anyway, that these young men and women may have already

been suffering from something, including personality disorders that later lead to suicide. This is from, you know, men who have been in the Service for 10 to 15 years who, all of a sudden, have personality disorders? You have to ask the question: How come nobody picked up on that earlier?

And, finally, one of the things that I haven't heard talked about here at all today is the sexual trauma that many of our young women veterans have experiences, not just in this war but in the previous war in the Gulf, in the first Gulf War. I think that it's really important for that issue to be addressed because these women are suffering from serious trauma, serious posttraumatic stress disorder, and oftentimes

they're forced to stay under the same command to which the violation occurred.

And then for regular military, what I'm hearing from some of them who are still serving, who haven't gotten out yet, is that they are absolutely tasked out from repeated deployments without enough down time, far too many hours worked when they do get back -- 12-to-16-hour days, six and seven days a week

in the field -- keep the men's certifications up. They have no down-time, and they're burned out.

I'd like to share just two very, very brief situations with you. One is about a Marine Reservist who was in Iraq for the invasion. He came home in July of 2003. He seemed to be doing okay, but started drinking. At first he said it was just to sort of let off a little bit of steam, but he every rapidly started decompensating.

He was hospitalized in late May of 2004. He was in and out of the hospital over

a series of days. They finally told him that he needed to get his alcoholism under control before they could deal with any diagnosis for PTSD or anything else that was going on.

On June 22nd his parents came home to find him hanging in the basement by a garden hose.

He committed suicide because he couldn't get the treatment that he needed.

Another soldier recently was on depression and suicide watch for less than a month between August and September. His contract was actually supposed to be up this

month. He -- no, I'm sorry, it was not this month, it was a year ago -- his contract was supposed to be up this month -- in November. He was stop-lossed in October. He went to Kuwait last March, and then sent to Ramadi in August. He is currently still in a war zone. He is very, very depressed, and I don't know what they're doing to take care of the suicidality that he's suffering from.

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The group debriefings that the soldiers, the veterans receive when they come home, are far too general. In the focus groups that where we've talked to many of these veterans, they've said, "What guy is going to stand up in those things and say, `I have problems?'" They said there's too many people in them, they're not going to talk in those groups, and that they're just too general. Things like, "Okay, guys, don't go home and kick the dog because you're angry. You need to go get counseling," does not serve them or their families well at all.

And speaking as the mother -- for a moment I'll take off my researcher hat -- speaking as a mother of a veteran, the FRG groups I thought were absolutely appalling.

I talked to a number of young women who were involved with the FRG group, and I'm sure that these aren't consistent. I'm sure that they vary across branches of military and where you are.

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But from the younger women what I was hearing, the wives, was that they were absolutely of no help at all. What they basically were taking care of was things like, where do you shop to get the best deals on clothes or food? Or, occasionally, how do you balance a checkbook? But not real good support. I think there needs to be better structure in place for the FRG groups to support the family members, including the parents.

The parents seem to be the step-children who are kind of pushed off to the side. We get very, very little information.

So what am I asking for? We need more funding for services, especially vet centers. The vet centers are crucial. One of the things that we're hearing from veterans coming back is that they want to talk to other veterans. They want to talk to

people who've had the similar experiences to

what they've had, who will understand what they're been through and be compassionate with them.

We also need to expand the definition of family. Currently, it's, if you're married to somebody or the child of somebody, you can get help. But oftentimes we've got fiancees, who are the closest individuals to some of these veterans returning, and something happens. The fiancee can't get any support because she's not considered family, yet she's the one who has been acting as family. So really need to look at the definition of family and who, you know, which significant- others should be more involved.

I think it was mentioned earlier, funding for health care providers, practitioners. I would also expand that to first responders such as police and firefighters, who take the calls when somebody's hurt. I spoke to a woman down in

Texas whose veteran husband was beating her up. He had his hands around her neck. Her four-year-old son and eight-year-old daughter were there in the room.

The eight-year-old called to the police and said that daddy was hurting mommy, and when the police showed up, one of the first thing the veteran said was, "I just got back from Iraq."

And the police clapped him on the back and shook his hand, and thanked him for his service to the country. Long story short, they ended up leaving the four-year-old boy with the father in the home that night and telling the mother to take the daughter and go to a friend's house. Very, very disconcerting.

And I guess the last thing, I wouldn't be true to my public health roots if I didn't talk a little bit about prevention. And I think probably the best way to prevent these sort of things in the first place is to

not send our troops off to war.

Thank you.

LTG KILEY: Thank you.

(Applause)

LTG KILEY: Could I ask you one question, please, before we get to the next commenter?

AUDIENCE MEMBER DR. WRESSLER: Abso lutely.

LTG KILEY: I'm interested in your comments about the -- what you said about treatment in the field --

AUDIENCE MEMBER DR. WRESSLER: Um-h mm.

LTG KILEY: --where you have concerns. Could you tell me a little bit more about what your perceptions are, what you know about that, or what you're hearing about that?

AUDIENCE MEMBER DR. WRESSLER: What we're hearing from veterans who are actually returning, and some of their family members,

is when they start decompensating in the field, in order to be able to pull them together so that they can function they are being prescribed things like Prozac and antipsychotics, given three days of down-time

to pull it together, and then resume duty.
So rather than pulling them way out and
sending them to Germany or bringing them
home, they're keeping them in the field.
LTG KILEY: Okay, thank you very
much.
AUDIENCE MEMBER DR. WRESSLER: You'
re welcome. Yes?
LCDR WERBEL: I have a couple
questions for you also. You mentioned that
one of the things you're hearing from --
that's -- is from veterans is that what would
help them in talking about these issues is
vets talking to other vets.
AUDIENCE MEMBER DR. WRESSLER: Um-h
mm, Um-hmm.
LCDR WERBEL: And one of those

resolutions to that, or one of the
recommendations, was more funding for the
veteran centers.
AUDIENCE MEMBER DR. WRESSLER: Um-h
mm.
LCDR WERBEL: I wonder if you've
heard of other examples of that from the
service members you've spoken to, either
veterans or maybe active- duty members who

have given you suggestions of what would increase their likelihood of talking about the problems they're experiencing.

AUDIENCE MEMBER DR. WRESSLER: One of the things I've heard consistently in talking with vets is that they don't want to go through government agencies. They're really, really, hesitant to participate in anything that they think is linked with the branch of military with which they're affiliated. There's a real concern about think- for-those-who-are-still-in for things getting back to up the chain of command and

what the possible implications or repercussions of that might be.

From others who are out, we have heard about such negative experiences from their perceptions about their, you know, being in the military, that they don't want anything that is in any way, in their minds, linked to military or government.

So my recommendation is better coupling with community-based organizations, with civilian organizations. I think that if they had opportunities to go outside and receive treatment, you might see more

veterans actually making use of those services.

LCDR WERBEL: Thank you.

AUDIENCE MEMBER DR. WRESSLER: You're welcome.

LTG KILEY: Thank you very much.

AUDIENCE MEMBER FOLEY: My name is Judith Foley, and I want to thank you for taking the time to listen to a small part of

my story. I'm a retired nurse with a master's degree in counseling.

I've spent most of the first year of my retirement glued to the television watching the news from Iraq. I am now just recovering from what I describe as the year I spent paralyzed.

My daughter was a surgical nurse in the Army and part of one of the few teams trained for the combat support hospitals. She is the mother of two, and at the time of her deployment they were two and five years old. She intended the Army to be her career until she realized that there were not enough teams to keep her from being deployed again and again.

Not willing to leave her family

again, she resigned as a major after 10 years of service to her country. My daughter came home from Iraq without physical wounds; my daughter did not come home from Iraq without emotional wounds that have not been addressed

by the military.

Following is a letter which I received while she was in Baghdad. The expectation that any of our veterans would be able to face such experiences and worse day after day without damage to their mental health is naive. This letter was written September 3, 2003.

"Dear Mom: "I hope that my letter finds you well.

It's time to come home, yet we can't. I'm so tired of the killing and the ugly injuries. Last night will be the second time I've cried because of a dead soldier. I needed to write to you because of our bond as nurses. I'm sorry if it is a disturbing note, yet I know that you will understand my sadness.

"He was 31 years old hit by an RPG," and then at that point she put parenthesis "(rocket propelled grenade.)

They usually come out of nowhere.

Apparently, you never see the RPG until it hits. He rolled in about 2:00 a.m., his left flank gone, abdominal contents spilling out. He was intubated and ashen-colored but still alive, his left arm mangled, and we couldn't get his wedding ring off. His left hip was broken and pelvis hard to tilt.

"Four surgeons, two anesthesia providers, two nurses, and two TIPS. We gave him 15 units of whole blood. They called for a volunteer blood drive from the hospital staff, copious amounts of IV fluids, and all of the other things.

"The first surgery they packed him and let him rest and warm up. We had a hard time keeping him warm even in Iraq. The ortho-surgeon proceeded to take off his left arm. First he handed me his wedding band and said, 'Someone needs to get this.'

"Mom, my heart just sank. I went into the hallway of the ER and said, `Colonel, who gets this ring?' Then one of

145

his soldiers stepped up with a bagful of his other contents and said, `I'll take it.' He asked me if he was going to lose his arm, and I replied, `He already has. I'm so sorry.'

"Less than an hour later the surgeons opened him up again as the blood was oozing out and dripping on the floor. The doc tried to stop the bleeding and closed him up again. His blood count was so low and his heart rate and blood pressure, too. They decided then to give him the 15 units of whole blood and then see how he was doing after. By then it was 0700 and shift change.

"We gave report and left. He died at 0805. We worked on him over five hours. Gone. He was probably gone when he came in, but he was an American. They weren't going to give up without a fight. The staff rallied last night and did their best to help him, from the pharmacy to lab, to the folks who donated blood it was amazing and is amazing to see how we always come together

146

and work as a team during these times. I

just wish we could have saved him. Awful.

"Whoosh. I'm tired after writing. Thanks for listening. Luckily, we have a great group of OR nurses who work together and take care of each other. I just hope that his wife will be able to get through this somehow, someday. I hope that she has family and friends around her. I can't imagine what it would be like to receive a call or visit telling you your loved one was killed in Iraq.

"He had his unit with him, he was not alone. They waited in the hall of the hospital hoping. I love you and miss you. Thank you for being there."

She's suffering now, and she's been out for I think two or three years, and I've heard it now here is what we need is the outreach for people like this who are out and have -- life's full and have not small groups somewhere for them to go to, and they don't

go. They can't seek. She's living in a place where she would have to go to the VA in a large city in a not-nice part, and travel in the traffic, and she has -- she won't talk to any of us.

This is the most I ever got from her. And when she came home, she won't talk to her husband, she won't talk to me, she won't talk to anybody. She's told me the only people she's comfortable talking to are the people that were there with her, and now that she's out she doesn't have that support. Those people are all spread all over.

This, to me, is what's necessary. Otherwise, she's going to be -- she's going to hit the wall soon if she doesn't get some help and real --

Thank you.

LTG KILEY: Thank you. We might want to talk to you afterwards a little bit and see if we can get some more information without violating her privacy. But we'd be

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happy to talk to you about maybe working some strategies for your daughter.

AUDIENCE MEMBER FOLEY: Okay, thank you.

AUDIENCE MEMBER DALTON: Hello.

LTG KILEY: Hi.

AUDIENCE MEMBER DALTON: My name is Ronnie Dalton, and I'm Jamie Dalton's mom. James Andrew Dalton, and he died early Friday

morning, April 14, 2006, at Fort Benning.

Jamie joined the Army right after high school. He really loved adventure, and he was in the Infantry. He was part of the NATO Peacekeeping Forces in Kosovo, and he was part of the initial invasion of Iraq. He was attached to the 269 Armor, and they saw a lot of action there.

He had a pretty good time, actually. He -- he -- he loved that. I guess it was the adrenalin. He just shone there. And the last time he was stationed in Adwar south of Tikrit where Saddam Hussein

was found in the Sunni Triangle area. During the first time in Iraq, he was a gunner on a Bradley. His timing was a dismount.

I talked to him on the phone. That was about our only contact when he was in these areas, and as a mom I would ask questions. He wasn't always very forthcoming, but just some of the things that he'd experienced in Kosovo, an elderly woman had been tied to a chair and beaten to death in her apartment. The first time he was in Iraq there were scores of burned and blackened bodies with dogs eating them, dead

children, and he said that didn't bother him.

The second time attached to another company; he wasn't with is buddies, they were in Samarra, and that really -- really bothered him. He also had to take leave after he'd been there for two months, and when he came back he had to stay for another 10, so that was kind of tough.

But when he was stationed at

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outside of Adwar, he made the comments that you could not trust the local police, and the Iraqi army was pretty useless. And IED went off in front of his HUMV about five feet, and it broke the windshield.

And he said he just hit his head and had the headache for a few days, but he asked me to send some mouth guards that he used when he played football to wear. But he wasn't allowed to wear those after a while because they weren't army- issued.

In August one of his very good friends -- he thought of him as his little brother -- was outside of Samarra, was in his Bradley and was hit by a grenade and ended up losing his eye and suffering brain damage. His dad was in Iraq at the same time, he was

a sergeant-major, and Jamie was very upset when this happened.

In November -- I always look at The New York Times on line, and I noticed that a company commander had been -- been blown up

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by an IED in his area, so when he called me a couple days later, I asked him about that. And he said, "Oh, yeah, that was our company commander." He was out in his HUMV with some other guys, and he said, "I got there almost right after it happened." He said a couple of the guys were still in the HUMV. They were really upset.

And he said, "I scooped up the commander's brains and them in the helmet," and he said, "but I'm over it now."

He was involved in a firefight with some insurgents on the highway after Christmas right before he came home, and he told me that they were on their way to Baghdad with explosives, and he -- they were --Jamie went up behind them with another fellow, and one was wounded. The second guy was trying to pick up a grenade, and they killed them.

And he was talking about taunting

them and yelling.

And I was thinking, you know, my son's yelling and jeering at these dead, and now I thought, well, better these families' sons -- sons than mine. One had a letter. He was from Yemen, and he had a letter from his family wishing him good luck on his mission. And the next day in Baghdad there were about, I don't know, between eight and ten suicide explosions in Baghdad.

Jamie got home last -- the end of last February, and we had a wonderful visit, and as a mom I talked to him about PTSD and wondered if, you know, he was experiencing any problems. And he said that he wasn't but he thought that he might have a little combat stress. He said that he noticed that when he was drinking, he could get angry pretty easily and would have to watch that. And then he also was kind of laughing, and he said he would start crying if he was watching some sappy-type movie with a buddy, and he thought that -- he thought that was pretty

funny.

So -- so he went back to Fort Benning. He had about 11 months more to go, and I actually thought he was doing pretty well. It was the first time that I had said goodbye to him and actually, you know, thought that he would be -- probably be okay. So he called me about two weeks later. He was in a bar and with his buddies and in very good spirits, and it was about 1:30 in the morning my time. And the next thing I knew, I got a call from his dad saying that, you know, Jamie had -- was dead.

And what had happened is he had gone out that night with friends, Friday night drinking, and which was pretty typical, and got separated from his friends. On the way back he took a cab, they all went in a car, and when he got back to his barracks, I guess Jamie had the -- he'd always break into his buddies' refrigerators and, you know, they'd be starving so he'd grab food, and

he'd either leave a $10-dollar bill or a note

saying that he'd take them out for lunch the next day.

Well, this particular time he got into someone's room that he -- I guess a new guy that was just out of basic that didn't know Jamie, and so he complained to the authorities. They sent a runner up to get my son, and he asked to go to his room to get an item of clothing, and he happened to have a loaded gun in the room and asked this fellow, the runner, to leave, and the runner refused. And somehow Jamie managed to be talked into going to the other facility, I guess just to kind of, you know, sober up, and -- but he took the gun with him.

And when he got to the other facility, he made -- there was four or five other, like, sergeants there, and he made them all sit down and watched them as he shot himself in the head.

I don't know that the army could

have done anything to prevent this from happening. He -- I think that it was just a perfect storm of the alcohol, and I think that the anger, something snapped. And being in the Infantry, having a gun is your way of

getting things back into control.

We just still can't -- we can't believe it. My daughter Katie and I flew back for the memorial the next week, met a lot of his friends, and that's -- I won't be much longer, but that's kind of what I want to talk to you about, about what his friends at Fort Benning said. They were stunned, you know. They said that was the last person that they had ever thought would do something like that. They were crying, they were phenomenal. They would not -- when my daughter arrived, they just kind of -- they -- they just wouldn't let us go. They were with us the whole time.

And I talked to them about the whole PTSD getting counseling and all that,

and at that time, which was in April, they said, they told me that it was really hard because you had to ask for counseling. You know, the onus was on you, you had to ask for it. They didn't trust anyone that had been in combat to talk to. They just didn't feel like a person that hadn't experienced what they had would understand.

They also thought talking in a

group with other guys was a little hard, and the whole --you know, you've heard this whole machismo thing of the military is very, very difficult to overcome when you're talking about emotional problems.

One thing that was interesting was that they mentioned a woman -- I don't know what her rank was, but she was either a psychologist or psychiatrist, he was no longer at Fort Benning -- but they thought that she was terrific. I don't know where she is now, but I thought that was really interesting that, obviously, she wouldn't

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have experienced combat but there was somebody talking about a woman that was -- that it didn't bother them at all.

And the, finally, I called them up, a couple of them -- two, three, four people up over the last couple of days to say that I was going to be here, and I wanted to ask them again about, you know, what they thought about mental health. I asked them what it was like when they came back from Iraq, either the first time or the second time for them. And they said that the meetings afterwards weren't much helpful. It was like

being at a high school -- this one fellow said, "Do you know what it's like being at a high school assembly? It was like that. You know, they give you the talk, and then they say, kind of with a wink, you know, if you need -- "Any trouble, you know, you guys have any problems, you know, we're here, dah-da-dah-da-dah." But it's just kind of perfunctory type event.

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Another thing was that it takes up to a month to get an appointment. That young man that was severely injured, lost his eye and also has brain injury, I'm in contact with his mom, and she said he husband's a career -- career Army, and she said that she tried to get her son an appointment to see a counselor, because after Jamie died he was really upset about that.

And she said that she had to make an appointment with a tech first, made the appointment, it was for two weeks. They showed up -- actually his dad took him -- and there was no record of the appointment. Somebody had, you know,

Dropped the paperwork. So she said they had to wait another two weeks to get an

appointment. So this was a month.

And she said, "I wonder what it's like for the combat arms guys coming back from Iraq that finally screw up their courage to make an appointment, and find out that

they don't have their name and they have to wait another month." She was pretty irate about that.

A couple more points. If you do get an appointment, the commander has to facilitate it. I was talking to another one of Jamie's friends that had some trauma problems when he got back, and he said they often won't allow you to go to the appointments. They have to let you out of your duty, and they think that you're trying to weasel your way out of -- out of your assignments. A lot of times you're labeled "a problem," if you ask to get counseling. It's just, you know, you're kind of a problem, a troublemaker.

Anther thing is there's no privacy, evidently. You speak to someone, and they can go back to the chain of command and discuss the entire conversation, which, you know, on the one hand, you know, I get it.

22 You know, it's the military, everyone has a

job to do. If you don't think they're up to doing their job, but on the other hand, it's also -- it makes it much more difficult if it's not just between you and the therapist.

There are some good things that are going on at Fort Benning. They are getting small groups together now. There's a PTSD group. It's six people, and it goes on for three weeks. I'm not sure, I think that might be the only group there, though. Every three weeks there's a new group. They also have groups -- stress groups, anger groups, grief groups, substance abuse, a lot of alcoholism -- a lot. A lot of self-medicating.

I talked to one of his friends last night. He was a sniper. He's going back. He -- he has to go back beginning of the year, and he seemed to think that there was help there if you asked for it. He said that the guys that have been there before are much more sympathetic if you ask for help now. So

maybe there is something that is something positive that's slowly, slowly evolving on the bases.

And, finally, after getting to know these fellows that were friends of my son's that loved him so much, I have to say that you look at their faces, and there's something in their eyes. They have old eyes, and when my son was home, he told his sister that he felt really, really old. And they also said, since it's a volunteer army, there's something -- that they think that since they've volunteered that they should have expected these things to happen, that they didn't feel like they really had the right to complain too much because they should have known what they were getting into.

Well, none of us knew what they were going to be getting into. So I just really am so glad to be able to be here today, and we owe them.

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We owe them everything. So thank

you very much.

(Applause)

LTG KILEY: Thank you very much, and our condolences on the loss of your son, and thank you.

We --

AUDIENCE MEMBER DALTON: He was just a phenomenal --

LTG KILEY: I'm sure he was.

AUDIENCE MEMBER DALTON: -- and -- thank you.

LTG KILEY: And we have learned something from talking to you today. Thank you very much.

AUDIENCE MEMBER FAIRWEATHER: Hello , my name is Amy Fairweather. I'm the Director of the Iraq Veteran Project for Swords Departures in San Francisco. Swords Departures is a community-based veteran services organization. We provide permanent and transitional supportive housing for

homeless veterans. Many of our clients are mentally ill. Many of them have languished on the streets for 10, 20, 30 years without getting the help they needed after combat in Vietnam.

So what we're doing now is we're talking to Iraq veterans, and we're conducting focus groups and gathering information directly from the vets about what's going on on the ground, and identifying gaps in services so that we can promote better policies for them.

And so what I'd like to talk to you about is, you know, what they tell us about the screening. They tell us again there's a big problem, that it's done en masse, there's no privacy, no one is going to raise their head and say, "I'm having problems," or even go to the back of the room and pick up that pamphlet on PTSD.

Another issue is they are told, either directly from superiors or from peers

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that if t hey fill out the questions on the postdeployment health assessment, showing that they did experience trauma or could be at risk for PTSD, they will say, no, no, no, no, no. They're told that if they do, fill it out honestly, they'll be put on medical hold, and all their buddies will go home, and they won't.

And, you know, at this point in

time they really want to go home.

Also with regard to the surveys, they're very concerned about the sigma of whether they're -- want to remain in the military or have federal jobs, or go into fire, or police, or security. And any kind of indication that they have mental health needs would be, you know, a problem with that. So they are saying no when, indeed, they are experiencing risk.

Some of the things that they have suggested to us is that if instead of filling out a form and being in a big room each

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person would go behind closed doors with a mental health professional, or even just a screener, I mean something, anything. And if everyone has to go behind a door and that door closes, they're not self-identifying and not where the stigma would be removed, and they might be willing to talk at that point or at least listen in a meaningful way.

Some of the other things we're told is the treatment out in the field in terms of stigma, you know. They're told that they're -- you know, words that I can't say here. They're -- are, you know, considered weak,

considered to be malingerers, considered to be trying to get out of duty.

One enlisted told me that an NCO staff sergeant had gone for mental health services, and he received such awful treatment, was treated so terribly that, you know, how would any enlisted man after that, after seeing someone with a little bit of rank get treated that way, you know, would

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they ever do that. And the answer is no. And again, there are privacy issues there about, you know, there's you can't really hide in the military.

In terms of those problems, I think, you know, what you should do, and my recommendation is it's got to come from the top down that any officer, any commander who allows that to happen and isn't disciplined, it's got to come from the top down that that kind of treatment will not be tolerated, whether it's from peers or whether it's from command. And otherwise, I don't any way to get across within the military culture to be nice, unless they're told, "Be nice or else." So -- so that is a big -- a big problem.

So again, you know, there's all

these programs, but when I talk to people on the ground, there are all these obstacles that still exist. And so, you know, it's not as effective as it should be.

I also just want to comment briefly

on this Task Force, and I'm really happy that it exists, and I think it's so important that you go around and you listen to the public testimony. And you've heard things here today that you're not going to hear from, you know, VA officials or, you know, or people who are on the time clock. You know, you're hearing the real deal here, and I would really hope that in the future you -- you schedule more time for public comment from, you know, good folks like this and let people know about the hearings, much -- with more advanced time so that people can arrange their schedules and be here.

So thank you.

LTG KILEY: Thank you very much. Thank you.

(Applause)

AUDIENCE MEMBER KOLKEY: My name is Zora Kolkey (?) and I've been a licensed nurse and family therapist in California for

20 years. And I was a civilian contractor in

the mental health field working with active-duty men and women in Europe. And the problems were intense, of course. But it was also -- it was not only the person in the Service, it was also families. I saw many spouses, many fiancees, and that program is so important, I think, as a preventive. It just really needs to be expanded.

And I've also worked with veterans in substance abuse programs, and those, too, need more funding, more help, and, hopefully, if the overseas program works, the incidence of the self-medicating and suicide and domestic violence will help. So I'm really glad you're here, and thank you, and thanks for listening.

LTG KILEY: Thank you very much.

(Applause)

AUDIENCE MEMBER JENSON: General Kiley and members of the Task Force, my name is Carl Jenson (?), and I come to you wearing as number of hats. I'm a member of

the Vision 21 Management Advisory Board; I'm the state commander for the California State Commanders Council; and I'm the Past National Chair for Posttraumatic Stress Disorder.

My background, I served with the 196 Light Infantry in July, in the summer of '67. Fortunately, when I was hit by a command-detonated explosive device, I came in on a Medivac on a slow day. My operation exceeded seven hours, eight pints of whole blood. The Army in its infinite wisdom cut orders allowing me to leave country after MASH unit and Quinyon Evac. I was pulled out in Clark Air Force Base because there were a handful of us who were thought not to be, have the strength for the balance of the flight to Camp Zona, Japan.

After 35 days there, I finally got -- came into Travis Air Force base, and was at Letterman General, Old Letterman General. My daughter was at the Larned Vanugillet--gilleteran General (?), which is

now gone. My point is, insofar as this Task

Force is largely made up of military personnel. As a combat retired Army personnel, I had the good fortune that Letterman was still open and not far from my home. When it closed, I used Hamilton Air Force Base, which is in Marin County, and later Oak Knoll's Naval.

The point is, with BRAC, returning soldiers do not have the luxury of as many medical facilities within the Department of Defense. I am glad to see the cooperation between the military and the Veterans Administration. Insofar as the Veterans Administration is on discretionary funds and not mandatory funding, there's an overload within the system, not only in retaining properly- trained, supervised personnel but to recruit replacements as they retire, particularly within the Veterans Vet Center Program. Most of those are combat vets themselves, and they are my age, 62 and

retiring.

And finding people that injured vets will go and talk to, as was stated earlier, they don't want to deal with the government; they don't want to go to a VA

Hospital. The storefront program with the vet centers is ideal because it's more peer-type counseling, and they'll trust that, will talk to themself. You don't -- if you're a combat disabled veteran and you're sitting with others, you don't have to go through the whole background, you relate to one another. You have a common bond.

You don't have to start and explain. The definition for posttraumatic stress, according to the Diagnostic Statistical Manual, is it is an abnormal, life-threatening event which would affect almost anyone other than a sociopath.

Every since there's been war there has been a term utilized for each generation. Civil War is was "melancholia." World War I

it was "shell shock." World War II, it's "battle fatigue." Korea, it was "war neurosis." Now we have -- there's something which I don't personally like, which is PTSD. If it's a normal reaction, why is it a disorder? We won't go into the semantics of that. When it was first identified and even before it was in DMS 1, it was referred to "posttraumatic syndrome."

My term that I've heard which is left over from the Civil War is "soldier's heart," and that really kind of sums it up. Not all war wounds are visible, and it's a silent one. The point -- the point is I believe inner-transfer of the information which was brought up by the Major earlier need to close that gap. So records, diagnosis, recommendations for treatment are facilitated from the Department of Defense to the VA system. So this is where your -- with your base closures, this is where, the only place, that they have to go.

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You've got CBOC which is community-based outreach clinics. They're not all staffed with psychiatrists. There are many professionals afield that don't even believe that posttraumatic stress exists, that it's a figments of our imagination or we're malingers, and we simply are trying to get three-hots-in-a-cot or float.

There's seven pages of testimony I've submitted. Yes, in the interest of time I'm not going to go through the whole thing. Many of the issues have been brought up earlier.

If you have any questions, I'd be glad to try to field them as best I can. Hearing none --

LTG KILEY: Thank you very much.

DR. BURKE: Have you submitted that testimony? I mean --

AUDIENCE MEMBER JENSON: Yes, it's been to staff support. It's also going to Cynthia, and I'll see that the General gets a

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copy before I leave the room.

LTG KILEY: Thank you very much.

AUDIENCE MEMBER THORNE: Hello, my names Lee Thorne (?). I'm a combat Vietnam vet. I served on a carrier on the flight deck. I'm also a Founder of Vietnam Veterans Against the War, and was involved in the beginning of Twice-Born Men, which was the first West Coast program for people with combat stress. It was a peer-led program.

I also helped write the legislation for the Vet Centers. I also helped, by being myself, and going to a lot of psychiatric society meetings.

I helped establish the PTSD designation for a lot of the combat vets.

I got a couple of things to say:

One is what our experience was during Vietnam early on, when we started dealing with this issue, was that vets spoke most likely to vets. What is very strange to me today is that there's the mothers here. That we

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didn't have as much, and it's -- it's really wonderful to see, and I hope the mothers keep networking 'cause it's going to be very important to people coming home.

The peer counseling was the way it started and the way it grew, and the way that it's most likely to be trusted. Now, peers also include other vets who weren't in this particular war but mostly include people that were in this particular war. That was our experience as well.

The second way the -- the -- the length of time that you're going to be affected by PTSD has to be understood. First, and what happened after Vietnam was by 1979 we had twice as many people dead from car accidents, drunken episodes, suicides as had died in the war itself, according to a VA study. That period of time, which was between 19 -- the end of the war was '73, and '79, the first six years after the end of the

war, from '68 to '79 -- it was 11 years,

those first 11 years or so were very critical and, in fact, cannot happen this time.

By putting more resources into treatment, more resources into community programs like Swords to Plowshares, then the likelihood of that particular statistic being repeated is greater [sic.] It will be greater that it won't happen.

The third thing is that what we found -- the other thing I helped start was Follow the Dragon, which was the first social services program that was peer-led for Vietnam vets in Santa Rosa. When we designed that program, what we understood was that PTS, that our psychological issues was part of the picture but not the entire picture. The entire picture, we had a lot of different issues and things we had to deal with. People didn't want to hire us, you know, and I'm sure that's going to happen again.

They didn't want to hire us because of our reputation as crazy people and violent

people.

So we needed help getting employment so we could feed ourselves. We needed -- we needed -- secondly, we needed -- we had other medical issues besides PTSD that occurred after the fact, and they had to be recognized and dealt with.

And we needed sociability. We needed to be -- have time with other vets, with our family, and with our churches, and with our communities, much of which we didn't get much of when we got back. And people had to give us a break because we were kind of crazy.

Finally, the thing I wanted to say most is this testimony -- this testimony from the public, especially from the mothers, it's been very difficult to hear for somebody who has PTSD. I'm sure some of you know this, because -- it's very important to hear. I know how to breathe now, you know? I'm been through so much stuff at the VA, man, I'm a

consumer of your services, and a lot of that

has been very good for me.

But, you know, this is a long-term thing. The next few years are going to be very critical. If you don't listen to the active-duty guys when they get out, the new vets, use -- use whatever means necessary, use every -- every tool available to learn from the guys coming back what they need, what they want, and how they are. Don't make it up, then it'll work. Without that input it's not going to work.

Finally, the amount of people at Fort Miley -- and I'm not sure if this is true in other parts of the country -- but the number of people at Fort Miley who are working in mental health, especially in the PTSD clinic, is not nearly enough, not nearly enough for the new demand. So the amount of additional funding for the VA has to be quite large, especially in the medical area. Thank you.

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LTG KILEY: Thank you very much.

(Applause)

AUDIENCE MEMBER STEWART: I -- I want to get up one more time. I'm sorry, I'm so overcome by all of this. I have never

been so overcome in all of my lifetime. I remember the first hearings that we did in Desert Storm and that they said that we had no syndromes, and I saw a young man and he wheeled up in a wheelchair, and I said, "Oh, my God, I didn't know." And here I was that most of my time was with the flu, and I was a commodity broker, and I stole things from the Navy, and the Army, and the Marine Corps.

And I saw men that came back from the front, and they were killing dogs, and my best friend picked up 150 bodies, and I had all of those things, and I remember seeing a man that was going to blow up his wife and his best friend. And I went and told somebody, the first sergeant, I used the chain of command. The whole time of the war

I thought that there would be a hand grenade coming through my window because I didn't want to see this man go home and blow up children. And I remember all of this, and it's just struck me so much.

I remember as a sergeant, the NCO Corps of the United States Army is the best. I was a good sergeant, and you don't ever have to call me, "Sir." I know the NCO Corps

can do this job. We're the first line. I can never forget when a warrant officer was having misconduct, and I was only a Reservist in the port city of Al Jibal. Everyone thought that I had been the one that turned him in. I was not. I just wanted to go up to the front line unit, and the guy said whoever squealed on him, please raise your hand.

And I thought to myself I wanted to go up to the front very badly. I raised my hand. I will never forget in the port city of Al Jibal when the men of my motor pool got

up and clapped their hands. I guess that's a sergeant's job, and your job as officers is to take good NCOs that can pick out these men -- my condolences to your family -- I have never felt such things. I have seen sergeants blow their brains out in the port city of Al Jibal.

I just haven't thought about it in 10 years, I guess.

And I know as soldiers, as officers that went to West Point, you listen to the NCO Corps. And I know that what we've listened to tonight and today, we can do the

job. Thank you.

LTG KILEY: Thank you very much.

Okay.

SPEAKER: Give me just a moment.

I'm -- I'm a Navy veteran. So I'm a little nervous to speak to all of you, and I just briefly want to say that if you could please look into MST a little more, that would be very good. I wish that I could say that I

lost a finger or a knee while serving my country, but it's very humiliating for -- for -- for -- for me, just -- just to -- to have MST.

So the VA has some great programs, however, I wish that there were more -- I'm sorry -- that there were more programs for active-duty because if there were I -- I'd still be in the military. I'd still be serving my country. And so if you could please look into more resources for -- for young women, both in Iraq or Afghanistan, or state side on bases here, I think that that would be really phenomenal. Yeah.

That's all. Thank you.

(Applause)

AUDIENCE MEMBER JOHNSON: My name

is George Johnson. I'm a Navy veteran --

LTG KILEY: Hold on just a second.

Hold on just a second.

COL ORMAN: Thanks for your courage

in talking to us. We know how hard it is to

get it out.

(Applause)

LTG KILEY: Yes, sir?

AUDIENCE MEMBER JOHNSON: My name

is -- don't call me "Sir," I was an enlisted

man.

LTG KILEY: You work for a living,

right?

AUDIENCE MEMBER JOHNSON: My name

is George Johnson, I'm a Navy veteran of

Vietnam. I've been active in veterans'

issues since about 1967, and one of the

things from a personal perspective, people

have mentioned a Veterans Center Program. I

have to think that sometimes that's kept me

from going right over the edge to have those

handy and available. So that's one thing

that has to be done.

And what this sister over here was

talking about, in-service stuff before you

get out, that's -- that's really necessary.

But the main thing I came up here for, being

a sailor and having a nephew who's on a carrier over there right now, and a niece who's a corpsman at Balboa, who just got word that she's going to be assigned to the -- a Marine combat -- regimental combat team at Pendleton for deployment in April or May, and, you know, I know how a lot of us sailors were treated when we went places after we came back, you know.

And you going, "I was in the Navy." "Oh. Well, you're not a real Vietnam vet." You know. I was in the Gulf of Tonkin when they -- when they told that lie, because we were relieved by the Turner Joy and the Maddox. So I know a lot about that stuff. And, of course, I never got any blood on my hands or blood on my shoes, but I went through the whole nine yards.

And so what I'm saying is we can't treat the airmen, and the sailors, and the Coast Guard people, and other people who are not directly involved in battlefield

situations with any less respect and with any less degree of helping them. Of course, these brothers and sisters we saw with this traumatic brain injury and stuff like that, you know, they're obvious. But a lot of -- there's a lot of Navy people, and the Air Force, and Coast Guard people who never really -- I watched the war through a radar screen 'cause I was a radarman.

But we need to remember those, and you folks need to remember those people, also. And, you know, I've been through the whole thing: Drugs, alcohol, divorces, and all this stuff. And another thing is we used to say, my brother Fred, who died in March from the effects of Agent Orange, you know, he fought the VA for over 20 years before he got adequately compensated. And, you know, I think he should have got another 10 percent just for posttraumatic stress disorder from dealing with the VA.

And a lot of us Vietnam vets would

jokingly say, yeah, just -- and every time

you talked to somebody, "Well, file an appeal." And you finally, like I did, I just said, "I'm through with messing with it."

But, and then they say, "Well, get over it. Get on with your life." And what I'm saying is, you know, we need to make it more, more human, more people-friendly when you go to the VA and apply for things like that. And I just -- I just hope you folks come up with something like that that would -- would -- and don't forget the sailors, airmen, and Coast Guardsmen and people like that that also serve, and also end up with a lot of the effects of these wars.

Thank you.

LTG KILEY: Thank you very much. We're looking to have time for one more comment, and then I think we're going to have to wrap it up.

AUDIENCE MEMBER BEEKNER: I'll make it real quick. I'm Bart --

LTG KILEY: You have plenty of time, but --

AUDIENCE MEMBER BEEKNER: Okay, thanks. I'm Bart Beekner (?). I'm a Navy Reservist, also the Deputy Director of the

Veterans Home of California, at Yountville, and I just wanted to say a little bit about some of the things we've been thinking about the role for the state veterans' homes and veterans' programs in this continuous, or the seamless transition. We've had a lot of good help and encouragement from the VA at Palo Alto, and others, and some good folks like Cheryl Cook, my colleague here at the county Veterans Service Officer Network around the state, and I know I've got some great leadership by Tom Johnson as our state Secretary of Veterans Affairs.

But the Veterans Home in Yountville, basically, was established in 1884 by Civil War veterans because they were concerned that too many veterans of the Civil

War was out on the streets. And right now we've got a 500-acre complex in Napa Valley. We've got over 1,000 veterans living there. Six hundred of them are some of our beloved brethren that are leaving us to tell too soon from the Second World War, but also Vietnam, Korea, and others.

And don't overlook a veterans' home as a resource. Those are people up there

that it's a welcoming community. We've got people that understand what veterans are going through, and they're very willing to share that. As a matter of fact, people think of the veterans' homes as being the retirement centers up on the hill, but we've got to strap these guys down to keep them from coming out and driving down to Palo Alto and doing what they can to help.

We're also working on prototyping. It's an oral history program, it's multimedia. We've got a history over the years of job training, and we're working now

on a partnership, and our -- we mentioned the TAG of California, a National Guard Bill Wade, sending down some of his overworked troops from construction brigades to help us rehab a building so we can have 40 beds in the next couple of months to help transitioning veterans from Iraq and Afghanistan. And we've got a few private sponsors, and we're going to work to do that.

But I just wanted to say a little bit about the state veterans' homes and as we think about our seamless transition.

LTG KILEY: That's great. Thank

you very much.

(Applause)

LTG KILEY: Well, thank you all very much for your input. It's very, very important for all of us to hear your views, and your concerns, and your stories of a great service to our nation by your family members and of yourself. And I personally appreciate this very much. It's been very

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instructive for all of us.

On behalf of the Task Force, I guarantee you that this group is working very hard to pull together the solutions that we can recommend to the Department of Defense and the Congress to make our programs more effective, more robust, cast a wider net to make sure that we get everyone that needs care and help into the system.

If you have further input, and if you would like to tell us more, give us more input, my public affairs officer is the point of contact, Ms. Cynthia Vaughan, and her email address is up there.

We'll leave that up for a while. You can copy that down, and she's the point of contact for the Task Force to give us more

feedback.

So with that, Colonel Davis -- Davies, I'm sorry, it is Davies, is it not?

COL DAVIES: Yes, sir.

LTG KILEY: Colonel Davies. It's

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been a good afternoon, Colonel. Good job. Would you please close the meeting?

COL DAVIES: This concludes the open session of the DoD Task Force on Mental Health.

(Whereupon, at 4:55 p.m., the PROCEEDINGS were adjourned.)

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